DOCUMENT RESUME

ED 215 841 RC 013 347

AUTHOR	Sepulveda-Hassell, Sharon
TITLE	An Assessment of the Mental Health Treatment Process: Eliminating Service Barriers for Mexican Americans.
INSTITUTION	Intercultural Development Research Association, San Antonio, Tex.
SPONS AGENCY	National Inst. of Mental Health (DHHS), Rockville, Md.
PUB DATE	80
GRANT	MH-31212-02
NOTE	106p.; For related documents, see RC 013 348-351.
AVAILABLE FROM	Intercultural Development Research Assoc., 5835 Callaghan, Suite 350, San Antonio, TX 78228 ($9.50).
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	Community Health Services; *Cultural Influences; Delivery Systems; Group Dynamics; *Medical Services; *Mental Health Clinics; Mental Health Programs; *Mexican Americans; Models; Needs Assessment; Physician Patient Relationship; Socioeconomic Influences; Staff Role; *Therapeutic Environment; *Use Studies
IDENTIFIERS	*Texas

ABSTRACT

The mental health intervention process, which entails the 12 essential services to be offered by community mental health centers, is studied as an interactive process involving: (1) the cultural foundations within which mental health and illness are defined; (2) the range of cultural variability of Mexican American service recipients and their service needs; (3) the culturally based attitudinal and behavioral responses of the mental health service providers to Mexican Americans; and (4) the treatment approaches utilized with Mexican American clients. Mental health literature regarding the intervention process involving Mexican American service recipients and treatment models developed for use with Mexican Americans is reviewed. A treatment team service approach that incorporates clinical professionals and indigenous paraprofessionals in the delivery of a comprehensive range of community mental health services is proposed. The perceptions and attitudes of Texas community mental health center administrators and providers regarding the delivery of mental health services are explored. Underrepresentation of Mexican Americans at professional levels and the limited awareness of cultural treatment factors are discussed as indicators of the community mental health system's currently limited capacity to offer culturally relevant and linguistically appropriate services to Mexican Americans. Implications of offering bilingual/bicultural community mental health services are considered. (Author/NQA)

RC

MAY 1982
RECEIVED
ERIC/CRESS

ED215841

An Assessment of the Mental Health Treatment Process: Eliminating Service Barriers for Mexican Americans

by

Sharon Sepúlveda-Hassell, A.C.S.W.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Dr. Jose A.
Cardenas
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

RC013347

Copyright © 1980 by Intercultural Development Research Association

IDRA 2

IDRA BOARD OF DIRECTORS

Chairperson of the Board
Mr. Jesse Treviño
McAllen, Texas

Vice-Chairperson
Mrs. Jan Coggeshall
Galveston, Texas

Secretary
Mrs. L. Debbie Haley
Houston, Texas

Dr. James A. Forester
San Antonio, Texas

Mr. Jose Antonio Gonzalez
Fort Worth, Texas

Mr. Mike Hernandez, Jr.
San Antonio, Texas

Mr. James D. Lehmann
Eagle Pass, Texas

Mr. Othon Medina
El Paso, Texas

Mr. Fernando Piñon
San Antonio, Texas

Mr. Jesse Rangel
Lubbock, Texas

Ms. Tina Reyes
Houston, Texas

Mr. Mauro Reyna
Austin, Texas

Mr. Lanny Sinkin
San Antonio, Texas

Mr. William Sinkin
San Antonio, Texas

Dr. José A. Cárdenas
Executive Director

IDRA is a nonprofit, tax-exempt organization, the purpose of which is to provide information to the general public concerning equality of educational opportunity.

Front cover design by Sharon Sepúlveda-Hassell and David G. Ramirez

This publication was produced with funds from a grant (MH 31212-02) made to the Intercultural Development Research Association (IDRA), by the National Institute of Mental Health (NIMH). However, the opinions expressed herein are solely those of IDRA and do not necessarily reflect the position or policies of NIMH, and no official endorsement should be inferred.

AN ASSESSMENT OF THE MENTAL HEALTH TREATMENT PROCESS: ELIMINATING SERVICE BARRIERS FOR MEXICAN AMERICANS

by Sharon Sepulveda-Hassell, A.C.S.W.

ABSTRACT

Federal legislation mandates the delivery of linguistically appropriate, culturally sensitive community mental health services to linguistic and cultural minority groups. The underutilization of mental health services by Mexican Americans may, however, reflect the service delivery system's lack of understanding and appreciation for the significance of linguistic and cultural variables affecting the treatment process.

The mental health intervention process, which entails the twelve essential services to be offered by community mental health centers, is studied as an interactive process involving: 1) the cultural foundations within which mental health and illness are defined, 2) the range of cultural variability of Mexican American service recipients and their service needs, 3) the culturally based attitudinal and behavioral responses of the mental health service providers to Mexican Americans, and 4) the treatment approaches utilized with Mexican American clients. Mental health literature regarding the intervention process involving Mexican American service recipients and treatment models developed for use with Mexican Americans is reviewed. A treatment team service approach that incorporates clinical professionals and indigenous paraprofessionals in the delivery of a comprehensive range of community mental health services is proposed.

An exploration of the perceptions and attitudes of Texas community mental health center administrators and providers regarding the delivery of mental health services is reported. The underrepresentation of Mexican Americans at professional levels and the limited awareness of cultural treatment factors are discussed as indicators of the community mental health system's currently limited capacity to offer culturally relevant and linguistically appropriate services to Mexican Americans. The implications of offering bilingual/bicultural community mental health services are considered.

ACKNOWLEDGMENTS

Sincere appreciation is expressed to my colleagues at the Intercultural Development Research Association who assisted in the formulation of this publication. My special thanks are extended to Dr. Sally J. Andrade and David G. Ramirez, who offered me constructive criticisms, invaluable insights and the benefits of their research experiences throughout the development of the research concepts presented in this monograph. Mary M. Binder and Dianna Ross Coker contributed their editorial skills to the production effort. Dr. Jose A. Cardenas consistently offered his support and encouragement to the research efforts of the Mental Health Research Project. Special thanks are also due to Rosario H. Trejo, who offered her extraordinary talent as a typist and patiently and pleasantly supported this production effort.

MENTAL HEALTH RESEARCH PROJECT OF THE INTERCULTURAL DEVELOPMENT RESEARCH ASSOCIATION

The Intercultural Development Research Association's Mental Health Research Project (MHRP), funded by the National Institute of Mental Health, seeks to improve mental health delivery systems for Mexican Americans in the State of Texas.

The MHRP's major goals include: 1) a preliminary analysis of the effectiveness of the state mental health service delivery system and subsystems in providing services to Mexican Americans; 2) an assessment of the community mental health center concept as it relates to the Mexican American population; 3) the design of a bilingual/multicultural human service delivery model relevant to the mental health needs of Mexican Americans in Texas; and 4) the development of policy and programmatic alternatives to enhance the utilization of the state mental health service delivery system by Mexican Americans.

The MHRP has established a Texas Advisory Committee which consists of mental health service deliverers, professionals/academicians and consumer representatives from the five major geographical regions of Texas. The committee members serve as conduits for information dissemination and collection. To ensure maximum generalizability of the process and products of the MHRP, six nationally recognized professionals in the area of mental health and service delivery systems serve as consultants to the MHRP in the form of a National Advisory Committee.

The goal of the IDRA Mental Health Research Project is improved services for Mexican Americans in the state of Texas. Because a lack of agreement has existed in Census surveys and social science research as to the definition of a "Mexican American," potential problems emerge in attempting to compare data sources across regions or time frames. Terms encountered historically to identify this ethnic group include: Mexicans, Mexican Americans, Spanish-surnamed, Spanish-speaking, Latin Americans, Spanish Americans, Hispanics, etc. The term "Mexican Americans" is used consistently by the Mental Health Research Project to refer to this population, indicating those residents who are of Mexican origin or descent. References to specific data sources may at times utilize the exact label cited therein (e.g., "Spanish Americans"); it is assumed by the project that the overwhelming majority of any such individuals in Texas are of Mexican origin.

Mental Health Research Project Staff

David G. Ramirez	Project Director
Sharon S. Hassell, A.C.S.W.	Research Coordinator
Rosa Maria Moreno, M.Ed.	Research Associate
Louise Villejo	Research Assistant
Sally J. Andrade, Ph.D.	Project Evaluator
Rosario H. Trejo	Project Secretary

TABLE OF CONTENTS

Page

Introduction 1

Chapter I - Legislative and Policy Developments Related to CMHC Treatment Services 3

Chapter II - Dynamics of the Intervention Interaction: Its Impact Upon Mental Health Services to Mexican Americans 10

  The Cultural Orientation of Mental Health Practices 11

  Mexican American Clients: What They Bring to the Mental Health Treatment Process 15

    Client Socioeconomic Level 16

    Acculturation as a Factor in Mental Health Treatment 17

    Nature of the Client's Complaint 21

    Client Expectations of Mental Health Services 23

  The Treatment Provider: Variables That Affect Intervention 26

    SES and Cultural Disparities Among Therapists and Mexican American Clients 26

    Therapists' Attitudes Regarding Mexican American Clients 28

    Therapists' Roles in the Determination of the Treatment Process 29

  Treatment Approaches Utilized with Mexican American Clients 33

  Conclusion 36

Chapter III - Treatment Models Developed for Use with Mexican Americans 38

Bilingual/Bicultural Treatment Approaches 38

Behavioral Models 43

Organizational Models 45

Conclusion 48

Chapter IV - A Treatment Team: An Alternative Approach to the Delivery of Mental Health Services to Mexican Americans 49

The Role of Indigenous Community Workers as Seen in the Literature 50

The Treatment Team Approach to Mental Health Services 53

Favorable Therapeutic Factors Associated with the Treatment Team Approach 54

Applicability of the Treatment Team Approach to the CMHCs and Mexican American Clients 59

Conclusion 62

Chapter V - Roles and Perceptions of Texas CMHC Staff Regarding Services for Mexican Americans 64

CMHC Staffing Patterns in Relation to Treatment Services for Mexican Americans 65

CMHC Treatment Staff Perceptions Related to Mexican Americans 67

CMHC Staff Perceptions Measured at the Texas/New Mexico Symposium 75

Conclusion 78

Chapter VI - The Implications of Implementing Bilingual/Bicultural Treatment Services at CMHCs in Texas 79

Why Are Culturally Relevant Services for Mexican Americans Justified? 79

Implications of Delivering Bilingual/Bicultural Services for CMHCs 82

References 86

INTRODUCTION

The Mental Health Research Project of the Intercultural Development Research Association is conducting social policy research with the goal of developing a mental health services delivery model for the improvement of community mental health services for Mexican Americans in Texas. The exploratory and descriptive research process is studying various aspects of the existing mental health system in Texas including community mental health center (CMHC) staffing patterns and utilization reports, the governance patterns of the mental health services network, the accessibility of CMHCs in Texas to the state's Mexican American population, and the mental health services planning process. In an effort to address the fundamental mental health issue regarding the delivery of treatment services, the Mental Health Research Project has expanded its research agenda to include an examination of the mental health treatment process occurring between Mexican American service recipients and mental health service providers.

This monograph explores the primary cultural dynamics of the treatment process, as well as reviews the mental health literature regarding treatment of Mexican American clients. Among the treatment issues considered are: 1) the cultural foundations within which mental health and illness are defined; 2) the cultural diversity of Mexican American service recipients and their needs; and 3) the culturally based attitudinal and behavioral responses of mental health service providers with respect to Mexican Americans. Alternative models reported in the literature concerning the delivery of treatment services to Mexican Americans are also reviewed in the monograph. An additional service approach conceptualized by the author that incorporates the services of professionals and indigenous Mexican American paraprofessionals in a treatment team format is offered for consideration of its viability to and application in Texas CMHCs.

The monograph also reports the results of preliminary research efforts to assess the attitudes held by community mental health service providers regarding the delivery of mental health services to Mexican Americans and other culturally relevant issues. The data is compiled from structured interviews conducted during Mental Health Research Project site visits to CMHCs in Texas (Mental Health Research Project, 1980) and from the published evaluation of the Texas/New Mexico Symposium on the Delivery of Mental Health Services to Mexican Americans (Andrade, 1978). In addition, a cursory analysis of the staff composition at Texas CMHCs is reported to indicate the degree of Mexican American representation at CMHC staff levels engaged in the design and delivery of treatment services.

The monograph does not comprehensively deal with all the issues regarding the delivery of culturally relevant services to Mexican Americans in community mental health settings. Rather, the purpose of the monograph is to acquaint the reader with the body of legislation and social policy related to the mental health treatment process, including the federal mandates for the delivery of culturally relevant, linguistically appropriate services by CMHCs to special populations, such as Mexican Americans. Far too few mental health service providers and members of the communities wherein treatment services are offered are aware of the service criteria outlined by federal enabling legislation. Without such information, Mexican Americans and other special populations are limited in their efforts to hold CMHCs accountable for the provision of needed yet generally unavailable culturally relevant services.

Furthermore, it is hoped that the monograph will cultivate an awareness of the numerous variables affecting the delivery of appropriate and relevant services to Mexican Americans, as well as introduce varied treatment approaches that may facilitate an increased utilization of CMHC services by this growing number of Texas residents. In doing so, the goal is the development of a responsive Texas mental health system to Mexican Americans and other special populations.

CHAPTER I

LEGISLATIVE AND POLICY DEVELOPMENTS RELATED TO CMHC TREATMENT SERVICES

The provision of accessible and acceptable mental health services to Texas residents is one of the legislatively mandated responsibilities (PL 94-63) of the thirty community mental health centers (CMHCs) currently operational in Texas. The 1970 Census reports that the Hispanic residents of Texas, most of whom are Mexican American, numbered 2.3 million, or almost 19% of the state population (U.S. Bureau of the Census, 1973). Clearly, the Mexican American population currently residing within the state is much larger. Because Mexican Americans constitute such a sizeable minority population within Texas, one would expect them to utilize community mental health services in proportionate numbers. Mexican Americans should in fact overutilize mental health services due to the fact that they generally have been only marginally integrated socially and economically and, therefore, experience higher levels of social, psychological and economic stress (Report of the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans, 1978). The documented underutilization of mental health services by Mexican Americans in Texas and elsewhere (Bachrach, 1975; Cuellar, 1977; Jaco, 1959; Karno & Edgerton, 1969; Kruger, 1974; Ramirez, in press), however, creates doubt regarding the effectiveness with which mental health services are being delivered to this minority population.

In light of the paradox inherent in the underutilization of mental health services by Mexican Americans, it is useful to examine the treatment process in order to determine whether culturally incompatible treatment services are linked to the underutilization phenomenon. The treatment intervention* that occurs between CMHC staff and local service recipients is extremely important because it is the fundamental mechanism through which the legislatively defined purpose of CMHCs is realized. Furthermore, through their delivery of treatment services, the CMHCs come into contact with the community members whose mental health needs justify the existence of the centers.

As much of the impetus for the creation of the CMHC network originated at the federal level, a body of legislation and policy recommendations was generated regarding the type of service to be delivered by CMHCs. A review of that body of law and policy clarifies the range and caliber of treatment services to which Mexican Americans, as all American residents, are entitled to receive from local CMHCs receiving federal assistance.

Following the 1963 passage of PL 88-164, which authorized federal assistance for the construction of community mental health centers, a new era in the delivery of mental health services began. The community mental health concept developed as an effort to meet the increasing numbers of apparent mental health needs while allowing service recipients to remain in their local communities. The proponents of community mental health services envisioned the community-based approach as a means to best meet local needs as well as to decrease the number of citizens requiring expensive institutional care. It was also anticipated that community services could exert preventive efforts to reduce the incidence of serious mental health disturbances while offering a support system for previously institutionalized citizens (Bloom, 1973).

---

*Treatment or intervention process will be used interchangeably to denote the full range of mental health services delivered at CMHCs, such as psychotherapy, chemotherapy, occupational therapy, recreational therapy, day treatment or partial hospitalization services, inpatient services, emergency services, and consultation and educational services.

The mechanisms for the delivery of community mental health services evolved through the passage of subsequent legislation (Brusco, 1979). The passage of PL 94-63 in 1975 resulted in an expanded definition of the range of comprehensive services that must be offered by CMHCs receiving federal assistance.

PL 94-63 outlines twelve essential services to be offered by CMHCs. Six of the twelve areas are to be available upon the establishment of center operations. These six include: 1) inpatient services, 2) outpatient services, 3) emergency services, 4) assistance to courts in screening individuals being considered for referral to a state mental health institution, 5) follow-up care, and 6) consultation and education services. The additional six services, which are to be phased in over the subsequent three years of center operation, include: 7) partial hospitalization, 8) children's services, 9) geriatric services, 10) transitional and follow-up services, 11) alcoholism services, and 12) drug abuse services (Hall, 1979).

Within its expanded definition of community mental health services, PL 94-63, Sec. 206(c)(7)(D) calls for the delivery of linguistically appropriate, culturally sensitive services. The legislation further requires that a CMHC serving a sizeable population of limited English-speaking individuals develop a program plan responsive to the needs of those individuals. Furthermore, it is mandated that each such CMHC identify staff members who could serve as linguistic and cultural liaisons to the special population service recipients as well as to provide guidance to other staff in the appropriate delivery of services to the special population.

The 1977 passage of PL 95-83, which contains amendments ensuing from PL 94-63, spurred the development of Guidelines for CMHC Services to Minorities by the National Institute of Mental Health in 1978. As noted in the Guidelines, PL 95-83 mandates that the programs of CMHCs be made available, accessible to and effective for all citizens in accordance with the intent of PL

88-164, PL 94-63 and Title VI of the Civil Rights Act. Regarding services, the Guidelines state that:

- Community mental health center service programs and treatment modalities should at a minimum be planned and implemented in such fashion as to ensure an accessible, equitable and appropriate response to the unique life experiences of minority catchment area residents.

- The CMHC should implement programs, policies, and procedures which will assure that all board members and staff will give specific attention to the identification and elimination of practices which impede the delivery of effective and equitable services to minorities. Examples of procedures and practices which should be examined and modified as indicated include: staff behavior at intake; criteria used to determine which staff are assigned to work with minorities; referral determinations; diagnostic procedures, including the use of culturally biased tests; and treatment modalities.

- Continued attention to these practices is needed to assure that the management of the CMHC is not contributing to such well documented problems experienced by minorities as low utilization rates, inappropriate diagnoses and treatment modalities, and disproportionately high dropout rates.

- The presence of these problems often indicates that staff and board members are not adequately informed about the life experiences and cultures of minorities and may be insensitive to the impact of staff behavior upon minority clients or catchment area residents.

- Staff should become aware of and be sensitive to the unique life experiences and cultures of many minority clients which are related to lifestyles developed from the clients' experiences with racism. The minority client's psychological attitude toward the CMHC and its staff may include distrust and inhibitions to being genuinely self-disclosing. Board and staff members should be aware that this is likely to have a profound impact upon the development of rapport and to adversely affect therapeutic relationships with minority clients. Appropriate responses to this situation will require sustained attention to the manner in which services are planned and provided.

- An appropriate response to these issues should include at a minimum the implementation of a wide array of flexible and accessible services; multi-racial, bilingual, and bicultural staff; and extensive outreach programs which have been designed with the active involvement of minority catchment area leaders and minority staff (Sharfstein, pp. 1-2, 1978).

The Guidelines' intent is to secure compliance with Title VI of the Civil Rights Act of 1964, as well as the legislation specifically related to CMHCs. Title VI mandates that:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. (42 U.S.C. S 2000d)

Several implementation regulations were issued by the Department of Health, Education, and Welfare (HEW) in order to assure the equitable treatment of all individuals by federally assisted programs. Several of the regulations pertinent to the delivery of culturally acceptable services to Mexican Americans by CMHCs are listed. The regulations prohibit the following discriminatory actions:

- denial of any service, financial aid or other benefit because of a person's race, color, or national origin, 45 C.F.R. S80.3 (b) (1) (i);
- providing any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others because of the individual's race, color, or national origin, 45 C.F.R. S80.3 (b) (1) (ii);
- treating an individual in a separate and/or unique manner in any matter relating to his or her receipt of any service, financial aid, or other benefit because of the individual's race, color, or national origin, 45 C.F.R. S80.3 (b) (1) (iii);
- restricting an individual's enjoyment of any advantage or privilege enjoyed by others because of the individual's race, color, or national origin, 45 C.F.R. S80.3 (b) (1) (iv);

- treating an individual differently from others in determining eligibility because of the individual's race, color, or national origin, 45 C.F.R. S80.3 (b) (1) (v);
- denying an individual the right to participate in programs on the same basis as other participants because of the individual's race, color, or national origin, 45 C.F.R. S80.3 (b) (1) (vi); and
- discrimination against an individual resulting from the utilization of criteria of methods of administration that have the effect of defeating or substantially impairing the objectives of federally assisted programs with respect to individuals of particular race, color, or national origin, 45 C.F.R. S80.3 (b) (2).

Despite the existence of such regulations, there is widespread concern among national minority groups regarding the perpetuation of discriminatory acts against minority Americans by federally-assisted programs (Owan, 1980). A consortium of eleven minority advocacy groups reported to HEW that persistent and extensive acts of discrimination occur within HEW-funded programs against non-English and limited English-speaking individuals (Hogan & Hartson, 1978).

When such adverse circumstances continue to influence the delivery of services to minority groups despite federal efforts, it is difficult to determine whether they are the result of malfeasance or nonfeasance. As noted in the NIMH Guidelines previously cited, the perpetuation of treatment inadequacies with respect to minority populations may result from uninformed and/or insensitive individuals engaged in program design and service delivery. Conversely, individuals who may be sharply attuned to the treatment needs of minority groups may be unable to impact the prevailing treatment regimen.

A growing volume of mental health literature concerning culturally relevant services to Mexican Americans is being developed by Mexican American and other culturally sensitive scholars, researchers and practitioners. Nonetheless, many administrators, practitioners and interested parties involved in the Texas community mental health system remain uninformed regarding the basic elements of the treatment process impacted by cultural and linguistic factors. The author assumes that the design and implementation of a mental health service system responsive to Mexican Americans will be promoted by the inclusion of culturally relevant literature and research reports in the mental health program planning and service delivery processes. A selected review of several critical treatment factors identified in mental health literature regarding the Mexican American service recipient, the treatment provider (who is generally not bilingual or bicultural), the culturally determined perceptions of mental health and illness, and diagnostic and treatment approaches is presented in the following chapter.

CHAPTER II

DYNAMICS OF THE INTERVENTION INTERACTION: ITS IMPACT UPON MENTAL HEALTH SERVICES TO MEXICAN AMERICANS

Community mental health centers vary widely in numerous respects, including their physical facilities, the specificity of their role in serving the community, management and staff operations, the variety of services offered, and the reception and utilization of available services by the local community. Perhaps the most apparent commonality existing among CMHCs is that all are designed to offer mental health interventions intended to prevent or ameliorate mental and emotional distresses. Intervention is used here to denote a broad range of activities related to mental health services such as preventive, educational, consultative, advocative and therapeutic activities delivered by CMHCs to the service recipient. The efficacy of any intervention is influenced by a complex cluster of interrelated variables such as the availability and accessibility of the service, the suitability of the center's ambience, the complex interaction between the service deliverer and potential recipient, the dynamics of the problem being addressed and the type of intervention undertaken.

Four interaction factors are of particular importance in the effective design and delivery of relevant, appropriate community mental health services to Mexican Americans. Among these are: 1) the cultural foundations within which mental health and illness are defined, 2) the range of cultural variability of Mexican American service recipients and their needs, 3) the culturally based attitudinal and behavioral responses of the mental health service providers to Mexican American clients, and 4) the treatment approaches utilized with Mexican Americans. These four factors will be examined in order to illustrate their influence upon the utilization and outcome of mental health services delivered to Mexican Americans.

THE CULTURAL ORIENTATION OF MENTAL HEALTH PRACTICES

Cultural distinctions play a significant role in the definition of mental health and illness with regard to Mexican Americans and other ethnic groups. Although there is still a lack of scholarly consensus regarding the cultural and individual interplay that draws the limits of normative and aberrant behavior, it is generally acknowledged that varied norms exist between ethnic cultural populations.

Gregory (1978), for example, describes the highly traditional Hispanic world view as weaving together the natural world of scientific medicine and the supernatural realm of religion and spirituality into one balanced system. The maintenance of balance is essential to the individual's health. No distinction is made between psychological and total physical well-being in traditional Hispanic thought. Relief for mental and emotional illness, therefore, is traditionally sought within medical and religious processes rather than the psychotherapeutic treatment designated by the prevalent Anglo culture as the preferred treatment for mental illness.

In the field of cross-cultural psychiatry, Torrey (1973) identifies several similarities in the healing processes performed in several cultures. In order to deliver meaningful, effective, therapeutic services, the "healer" and the "patient" must share a similar world view that enables them to name and treat illness in a mutally compatible manner. The techniques of treatment must also be jointly acknowledged as appropriate and useful. Finally, the personal qualities of the "healer" and the location where the treatment will be administered must have substantial significance to the "patient," such that the therapeutic process is facilitated.

The limitations of traditional, Anglo-oriented systems of mental health care to serve Mexican Americans may well originate in the system's failure to acknowledge and incorporate the cultural distinctions regarding the treatment of illness that exist in the Hispanic, as well as other, cultural belief systems.

As is reported in the Chicano Plan for Mental Health, Torrey addresses the discrepancies between majority and minority groups' mental health norms and service needs as follows:

> The vast majority of service, delivered by highly trained professionals stressing insight and autonomy, evolved to meet the needs of upper-class Americans and are vaguely assumed to emanate from God-given principles. The resulting lack of class and cultural perspective produces services for minority groups that, when they exist at all, are both illogical and irrelevant. (Duran, 1975, p. 8)

The existing system of community mental health care is based upon Anglo-dominant cultural values, which emphasize the educational qualifications of the "healer" and are heavily oriented in psychodynamic theory (which separates the mind's functioning from the body and sets therapeutic goals such as insight and improved social and personal efficiency). Conversely, curanderismo, the healing process of the traditional Mexican American culture, emphasizes a religious orientation, integrates the client's social system and environment into treatment, has a holistic health outlook, and emphasizes symptom removal and improved interpersonal relationships as therapeutic goals (Torrey, 1973). However, assuming that all Mexican Americans would desire or benefit from the treatment of curanderos is just as incorrect as assuming that all of them can adapt to the prevalent mental health system. Cultural sensitivity to the individualized belief system of all clients, but particularly minority clients, is essential if services that will meet the client's needs rather than the system's needs are to be delivered.

In restating Torrey's thought on the potential flaws in cross-cultural interventions, Padilla and Ruiz (1973) note an additional problem of the inherent likelihood of professional misjudgment related to cultural unawareness of and insensitivity to minority group norms and standards of mental health. The extent to which Mexican American cultural systems are different or unique is extremely important when the cognitive, behavioral and emotional functioning of a Mexican American is being evaluated within the Anglo cultural framework that has predominated in mental health education and service delivery systems. Gomez and Cook (1978) note that personality dynamics and mental disorganization can best be understood by evaluating them within the social and cultural framework of the individual. This is particularly complex in the case of Mexican Americans, many of whom routinely move within the conflicting minority and majority spheres in an attempt to meet educational, employment, social and emotional needs.

In order to reduce the incidence of culturally based error in mental health services, administrators and clinicians must develop a sensitivity to the cultural variabilities in defining mental health and the stigmas associated with particular aspects of mental illness. Giordano and Giordano (1976) note that mental health professionals lack awareness of their own cultural background and thus fail to recognize cultural differences in emotional language, family symbolism, and family roles. These factors, as well as the prevailing tendency to apply universalized schemes of mental health to diverse cultural groups, lead to distorted, culturally incompatible mental health services. The two authors further suggest that clinicians cannot effectively treat other cultural groups until they confront their own prejudices that impact upon the services delivered.

In order to facilitate effective services to Mexican Americans, CMHC administrators and clinicians can assume an initiative to educate themselves about relevant cultural elements with which they are unfamiliar, such as the Mexican American philosophical viewpoint regarding self, significant others and society, as well as the cultural support systems operating within

Mexican American barrios. The service system can then be examined in order to identify and rectify the culturally insensitive aspects of traditional mental health services in addressing the needs of Mexican Americans. In addition to developing this "spirit of inquiry," as it is referred to by Gomez and Cook (1978), a pluralistic intervention outlook as conceived by LeVine and Padilla (1980) can be implemented to replace the ethnocentric character of typical mental health services. Although the conceptual content of the pluralistic paradigm will be elaborated upon further, it is based upon an awareness of the majority and minority cultures and the points of contact and conflict between them. The pluralistic paradigm also acknowledges the influence of cultural standards upon individual behavior and functioning. Such a pluralistic model also places emphasis on working with Mexican American clients in the language of their choice and on recognizing and strengthening their preferred ethnic identification and degree of biculturalism (contact with the Mexican American and Anglo American cultures). Above all, pluralistic mental health services attempt to facilitate each client's adaptation to the cultural milieu of his or her choice.

As one attempts to study the intervention interaction that occurs between community mental health service providers and Mexican American clients, the multiplicity and variability of factors that influence the outcome of the intervention are apparent. Assuming that the community mental health center is accessibly located and that it facilitates the Mexican American service recipient's entry into the system, there are three major variables that determine the nature of the intervention outcome: the client who brings a problem to be addressed, the service provider and the treatment approach chosen. Several aspects of the three factors identified will be examined in order to highlight the reader's awareness of circumstances influencing the Mexican American's use of mental health services, as well as to point out aspects of the intervention process that have been documented within treatment and research literature to be particularly significant with regard to Mexican American clients.

MEXICAN AMERICAN CLIENTS: WHAT THEY BRING TO THE MENTAL HEALTH TREATMENT PROCESS

Numerous researchers and authors have documented that many Mexican Americans maintain a positive attitude toward mental health services. Extensive work has been done in this area as researchers have attempted to explore whether a negative attitude toward therapeutic services would explain the low utilization rates of mental health services on the part of Mexican Americans. LeVine and Padilla (1980), however, report several studies illustrating that such negativism has not been the case. For example, Padilla, Carlos and Keefe's findings (1976) of an extensive stratified survey of Californians indicate that over 60% of the Mexican Americans questioned displayed a willingness to use local mental health services. The results of Karno and Edgerton's study (1969) of Anglo and Mexican Americans of similar economic status who resided in East Los Angeles find that 80% of both groups believed therapy could assist psychiatrically disturbed people, although 80% of both groups were unable to name or locate a mental health center.

Acosta (1977) reports that the study conducted by Acosta and Sheehan (1976) of Anglo American and Mexican American college students' attitudes toward psychotherapy found that the Mexican American students possessed a considerably more favorable attitude toward the potential usefulness of therapy than the Anglo American group. As Acosta points out, the positive attitudes displayed by Mexican American respondents in his study and that of Karno and Edgerton (1969) accentuate the contradiction inherent in the low utilization of traditional therapeutic services by Mexican Americans.

In reviewing the utilization of community mental health services at an East Los Angeles setting, Flores (1978) concludes that Mexican Americans are positively responsive to available bilingual/bicultural services. Trevino, Bruhn and Bunce (1979) report similar findings regarding a study in Laredo, Texas, where

Chicano clients demonstrated through high utilization rates a positive response to community mental health services that are designed to deliver bilingual/bicultural services.

In reporting the results of a research study conducted at La Frontera, a bilingual/bicultural mental health facility in Arizona, Chavez writes:

> The findings suggested that the majority of Mexican Americans in this study came to the Clinic equipped with insight and readiness to utilize the mental health services which they had requested. In addition, many of the respondents were eager to articulate their problems to someone who was sensitive, competent and willing to facilitate the problem-solving process. Hence, the individuals in this group, although economically poor and of relatively modest educational backgrounds, did not fit the stereotype of the lower socio-economic person who wishes for magical solutions to solve his mental health problem. (Chavez, 1979, p. 31)

The research efforts cited point out that many Mexican Americans possess positive attitudes regarding mental health services and that the reported usage of bilingual/bicultural services reflects their willingness to participate in therapeutic endeavors.

Client Socioeconomic Level

Due to the fact that the majority of the Mexican American population lives near or below the poverty level, it is important to ascertain the extent to which low socioeconomic status (SES) affects mental health services. Lorion's work (1973) indicates that poor, working class people have the least opportunity to receive therapeutic services from community service networks. Lorion's review of several studies reveals that poor clients can benefit from therapy as much or more than economically advantaged clients if the former's needs are appropriately addressed.

Nonetheless, Lorion finds that individuals from low SES backgrounds are either less often accepted into individual psychotherapy or that their treatment is of shorter duration. The poorer clients are also most likely to receive inexperienced therapists. Cobbs' research work (1972) supports the belief that therapeutic availability and expectations vary according to socioeconomic factors.

Other research indicates that poor Mexican Americans are doubly disadvantaged in their efforts to obtain psychotherapeutic services. Yamamoto et al. (1967) and Karno (1966) find that low-income Anglo American patients receive more individual therapy at public outpatient clinics than either Mexican American or Black patients. Acosta (1977) interprets these findings to mean that if a client is poor and an ethnic minority group member, as are the majority of Mexican Americans, the likelihood of receiving appropriate therapeutic services is very small. In spite of the obstacles that indigent Mexican American clients face prior to receiving extensive therapy, positive community mental health treatment results have been reported, such as the following excerpted conclusion:

> These findings demonstrate that a proportion of patients from lower socioeconomic and from a Mexican American ethnic minority group, primarily, do continue in psychotherapy for more than a few sessions and that they are rated by their therapists as improving or benefiting from this approach of treatment. (Kahn & Heiman, 1978, 261-262)

Acculturation as a Factor in Mental Health Treatment

One of the most important characteristics of the Mexican American client related to his or her role in the mental health intervention is the individual's dynamic process of acculturation. Acculturation is used here to denote the composite of a Mexican American's individual degree of behavioral and psychological identification with Mexican, Mexican American or Anglo culture, falling within a range extending from traditional Mexican orientations to complete assimilation of Anglo American attitudes, beliefs and mores. Many Mexican American individuals appear to have a repertoire of coping skills and flexibility which permit them to move within and between the three cultures. Cultural identification is a dynamic process wherein individuals of Mexican American origin can move towards or away from strong, visible ethnic identification. Each individual's level of acculturation is mediated by numerous factors such as place of birth, primary language, length of residence in the United States in terms of family generations, access to the resources of the majority culture, and the exigencies of adaption and survival within a hostile, racist environment. Miranda and Castro (1977) note that the "cultural distance" which separates the Mexican American and dominant cultures has forced some Mexican Americans to suppress or negate aspects of Latino culture in order to conform to majority cultural patterns.

The degree of compliance or cultural adaptation varies among Mexican Americans. In an anthropological study of Mexican Americans living in a Dallas barrio, Achor (1978) delineates the range of acculturation adaptations she observed within four categories: insulation, accommodation, alienation and mobilization. Much of the Mexican American client's response to traditional mental health services will be influenced by the adaptive style he or she chooses.

The tremendous heterogeneity of Mexican American lifestyles results in disparities in research findings assessing the role of traditional cultural elements. For example, in a 1966 study of Mexican American low-income housewives in Texas, Martinez and Martin (1966) report that 97% of the female respondents are familiar with folk illnesses, and that 95% have had close personal experiences involving the occurrence of folk illnesses and a willingness to utilize folk treatments. On the other hand, Padilla, Carlos and Keefe (1976) questioned a stratified sample of Mexican Americans in southern California. Their findings indicate that folk treatments are not identified as the preferred treatment for emotional disturbances and that many respondents have dubious or negative beliefs regarding the existence of particular folk illnesses. Acosta (1977) also reports the research results of Edgerton, Karno and Fernandez (1970) which reveal that only a few respondents from a substantial sample of Mexican Americans in Los Angeles would recommend folk treatments for emotional problems.

Several researchers have investigated the relationship between acculturation levels and mental health disturbances. As Acosta (1977) notes, limited definitive research has been produced regarding whether the acculturation process toward an Anglo American lifestyle negatively affects Mexican Americans. Ruiz (1977) asserts that acculturation levels influence the intrapsychic or extrapsychic nature of emotional problems experienced by Mexican Americans. According to Ruiz, intrapsychic problems are more characteristic of Mexican Americans who have developed numerous cultural similarities with the majority culture. Conversely, traditionally oriented Mexican Americans experience the extrapsychic stresses associated with minority group status in the ethnocentric majority culture.

In an effort to determine the impact of acculturation on the intervention interaction, Miranda and Castro (1977) tested whether high levels of behavioral and psychological identification with the dominant culture are correlated with seeking and remaining in psychotherapy. The authors studied Mexican American women who received mental health services for varied lengths of time. The findings indicate that, regardless of socioeconomic status, the subjects who remain in psychotherapy for longer intervals demonstrate higher levels of acculturation to the dominant culture than the subjects prematurely terminating treatment. As Miranda and Castro emphasize, their results support the contention that differential cultural expectations inherent in less acculturated Mexican Americans, rather than low

SES levels, underlie the low utilization of mental health services by Mexican Americans.

In considering the influence of acculturation on a Mexican American client's response to treatment, Casas (1976) identifies three frequently overlooked areas of cultural consideration relevant to the mental health intervention process. First, the human relational processes involving the client's perceptions of family, extended family roles, sex roles and societal interactions will affect his or her role in treatment. Second, the client's incentive-motivational style relates to whether the Mexican American individual externalizes or internalizes the locus of control over desired changes and cultural distinctions that result in differential motivational forces. Finally, cultural differences in learning styles may influence the Mexican American's methods of approaching and solving problems. These cultural distinctions, whether pronounced or subtle in individual cases, may influence the Mexican American's participation in and response to the intervention process.

One of the most evident signs of the Mexican American's link to the ethnic culture is the Spanish language. The documented failure of institutional mental health services providers to offer therapeutic services in Spanish is an equally evident sign of institutional barriers restricting the Mexican American's use of services. Ruiz, Casas, and Padilla (1977) cite numerous research studies of treatment facilities offering therapeutic services to either bilingual or monolingual Spanish-dominant individuals by monolingual English-speaking professionals (e.g., Edgerton & Karno, 1971; Karno & Edgerton, 1969; Torrey, 1973).

The number of Mexican Americans who consider Spanish to be their primary language is significant. According to Acosta (1977), the 1970 Census indicates that a large majority of Mexican Americans identify Spanish as their native language or the primary language of their childhood. LeVine and Padilla (1980) estimate that 50% of Hispanic mental health services recipients are Spanish-speaking. The need for bilingual therapists is apparent if the needs of this substantial segment of the population are to be addressed.

The use of non-professional interpreters during therapeutic treatment is considered to be an inadequate alternative to a lack of bilingual professionals. LeVine and Padilla (1980) suggest that the discussion of personal concerns through an interpreter conflicts with the Mexican American cultural value of dignidad (personal dignity, including privacy). The presence of a third party also hampers the trust and good communication between client and therapist that is essential to satisfactory, productive therapy. The limited confidentiality and privacy of the therapeutic session which relies on an interpreter for communication may well discourage Mexican American clients' utilization of services and represent institutional disinterest in their needs. An additional factor that must be considered is the quality of translation, as the linguistic adequacy of the interpreter is often not considered. Adequate mental health services delivery to Mexican Americans is dependent upon appropriate language matches between client and therapist. As Carrillo states:

> Clearly, without the rudiments of verbal commmunication between practitioner and client, the process of treatment is, at best, slow and inaccurate and, at worst, impossible. (Carrillo, 1978, p. 146)

Nature of the Client's Complaint

The nature of the difficulties experienced by Mexican American clients has important implications for the intervention interaction. As noted by LeVine and Padilla (1980), Mexican Americans often do not have experience in describing their problems in psychological terms but rely instead on somatic terminology to express their pain. This behavior pattern, as well as their traditional holistic viewpoint, may account for the heavy reliance by many Mexican Americans on physicians when treatment is sought.

Several authors report distinctions in treatment needs and outcome related to the type of difficulty identified by Mexican American clients. For example, Kahn and Heiman's analyses (1978) of treatment services in a barrio clinic indicate that clients who are self-referrals and active in longer treatment recognize the existence of psychological problems such as anxiety, depression, and social or familial incompatibilities. Short-term clients are characteristically non-self-referrals and identify their concerns as financial or situational problems.

Among much of the research literature, a distinction is made between the types of problems experienced by Mexican Americans. The existence of either external or internal stresses upon the Mexican American client is thought by Ruiz (1977) and LeVine and Padilla (1980) to influence the client's perception of the problem and appropriate intervention strategies. According to LeVine and Padilla (1980), three basic types of difficulties occur for which Mexican Americans seek treatment. The three categories of problem situations include:

1) when the Mexican American client experiences personal stress and problems similar to non-Hispanics,

2) when the Mexican American client experiences societal stresses, and

3) when the Mexican American client experiences stress originating from both personal and societal sources.

In an attempt to distinguish the type of problems encountered by Mexican Americans, Ruiz (1977) elaborates the intrapsychic/extrapsychic stress dichotomy and the significance of each in mental health services for Mexican Americans. Intrapsychic stresses include problems of an individual nature such as social or personal adjustments and psychological developmental issues. Intrapsychic stresses are experienced by all individuals and are suited to treatment by psychotherapy and other traditional interventions. If a Mexican American client is experiencing only intrapsychic difficulties, the client can be expected to benefit from culturally and linguistically compatible psychotherapeutic services as much as a non-Mexican American client would.

Extrapsychic stresses originate in the societal environment and include phenomena such as racism, sexism, discrimination, inaccessible educational and societal resources, and the negative social status associated with poverty and ethnicity. As members of an ethnic minority group, Mexican Americans experience substantial amounts of extrapsychic stresses that impair their self-concept and stimulate intrapsychic problems. Although both types of stress result in the experience of subjective discomfort, the Mexican American client has differing capacities to address and change the problems. New coping skills, cognitive styles and behavioral patterns can be developed to overcome intrapsychic stresses. However, the societal pathology inherent in the extrapsychic stresses is beyond the range of control of the individual Mexican American client. Sensitive discrimination on the part of the service deliverer between the types of problem the Mexican American client brings to the center would increase the likelihood of offering relevant assistance. The effectiveness of mental health services designed to address individual internal issues would also be complemented by some therapeutic efforts that address the prevalent extrapsychic societal stresses affecting Mexican Americans.

Client Expectations of Mental Health Services

The expectations or preconceptions that the Mexican American client holds regarding treatment are critical variables influencing his or her role in the treatment process. Miranda and Castro (1977) recognize that differential cultural expectations of therapist and client are often never clarified due to the failure to develop a positive communication system. This inadequacy prevents the development of mutual treatment expectations and results in a cultural impasse in the therapeutic process. If such frustrating treatment outcomes are to be avoided, the expectations of both the therapist and client must be addressed and be made consistent during the initial phases of service delivery.

One can reasonably assume that both therapists and clients approach the therapeutic encounter with some unspoken expectations. Buchanan and Choca (1979) report a study by Heine and Trosman (1960) which found that the mutuality of expectations between patient and therapist is positively correlated to the involvement of the client in continued treatment. In their study, Heine and Trosman found that in the group of clients who discontinued treatment prematurely, discrepancies were noted between the preconceptions regarding treatment held by the client and therapist. While the discontinued clients envisioned a "guidance-cooperation" therapeutic relationship, the therapists had maintained notions of a "mutual participation" process. Buchanan and Choca note that the expectations held by therapists significantly influence whether a client will be engaged in treatment. The authors conclude that the cultural differences that limit open communication between culturally diverse groups, such as Mexican Americans and most therapists, most of whom are Anglo, prevent early clarification of treatment expectations.

According to Chavez (1979), the responsibility of identifying and meeting client expectations lies with the service deliverer. Chavez studied a group of Mexican American clients who had received health services at La Frontera, a bilingual/bicultural facility in Tucson. Chavez reports that, prior to initial contact with a therapist, clients' expectations regarding services fall into one of three categories. Clients expect to receive either consejos (sharing and receiving through a discussion), direccion (direction or definite guidance), or relief from los nervios (a psychological, nervous anxiety rather than a physical problem). The clients expecting consejos demonstrate self-awareness, insight into their problems and see the therapeutic process as a means to self-development and problem resolution. The clients anticipating direccion look for concrete assistance and problem resolution with minimum participation on their part. The clients expecting relief from los nervios desire resolution of emotional well-being through counseling but envision themselves as being only moderately involved in the process. The clients anticipating consejos are most likely to continue treatment while those anticipating direccion tend to discontinue services.

The same sample of Mexican American clients see themselves as assuming one of four roles as the client in the treatment process. The four categories are labeled by Chavez as an active self, a non-committal self, a listening self and a vague self. These four roles reflect the range of possible client participation, initiative to be open and share with the therapist, and certainty of the role to be played by the client in the process.

With regard to the role of the therapist, the clients studied by Chavez expect the service provider to assume either a faith role, a sorter role, an omnipotent parent role or a nebulous role. In the faith role the therapist is expected to be an empathic, directive problem solver. The sorter role calls for the therapist to work with the client on identifying satisfactory resolutions to problems. As might be expected, the omnipotent parent type of therapist is expected to guide the client, and the nebulous role is anticipated when the respondents did not know what the therapist's role would be. Chavez's study indicates that the clients who anticipate playing active roles in therapy and expect a therapist who would sort out or facilitate the process are most likely to continue in treatment. Chavez recommends that mental health service providers assume the following stance:

> ...every effort should be made to discover, clarify and meet client expectations, such as the request for direccion. The mere fact that an individual expects direccion or initially views his/her role as a listener, does not justify labeling him/her as untreatable. Instead, the therapist must begin to recognize expectations brought by all clients, including Mexican Americans, and must begin to assume more responsibility for clarification if maximum utilization of services is to become a reality. (Chavez, 1979, p. 32)

Kahn and Heiman (1978) also recognize the significance of client expectations in treatment. They recommend that service providers educate potential clients regarding the nature of therapeutic services. The recommendation of pre-therapy orientation for clients is a constructive means of reducing the incongruence of client-therapist expectations.

THE TREATMENT PROVIDER: VARIABLES THAT AFFECT INTERVENTION

Practitioners, scholars and researchers in the field of mental health have attempted to identify and classify the essential elements of the effective therapist. Throughout the literature concerning mental health services to Mexican Americans, one finds numerous references to the characteristics and roles of therapists that serve to either retard or enhance Mexican American utilization of treatment. This section of the monograph examines the effects of the therapist's socioeconomic status, cultural perspective and value orientations upon the intervention interaction with a Mexican American client.

SES and Cultural Disparities Among Therapists and Mexican American Clients

Among the explanations offered for the low utilization of mental health services by Mexican Americans is the existence of incompatibilities in therapists" language, class and culture in relation to the clients' culture and social status (Padilla, Ruiz & Alvarez, 1975). Differences in the language used by the client and the service provider block accurate in-depth communication that is the basis of the effective therapeutic relationship. Despite this obvious prerequisite to effective treatment, the overwhelming majority of mental health professionals are Anglo American (Ruiz, 1971), and several studies have documented the use of monolingual, English-speaking staff in the delivery of services to monolingual Spanish-speaking or bilingual, Spanish-dominant clients (Ruiz, Casas and Padilla, 1977). If such clients are to be served, the obvious recommendation to be made is that community mental health services employ bilingual professional and support staff. Bilingual ability would also allow the service providers to initiate and work with "code switching" (ability to maintain comprehension while utilizing two languages) which may be a frequent occurrence among bilingual Mexican Americans.

The fact that most mental health professionals who treat Mexican Americans are monolingual, English-speaking Anglos results in cultural and class incompatibilities, as well as linguistic problems. The cultural difference between the middle-class Anglo therapist and the frequently indigent Mexican American client is an additional impediment to the therapeutic process. Ruiz, Casas and Padilla (1977) report numerous studies (e.g., Abad, Ramos & Boyce, 1974; Torrey, 1973; and Yamamoto, James & Palley, 1968) that substantiate the difficulty of creating and sustaining an effective therapeutic relationship between members of different SES groups who are also from different cultural backgrounds. According to Padilla, Ruiz and Alvarez (1975), studies by Karno and Edgerton (1969) and Kline (1969) reveal that therapists who deliver middle-class oriented services to Spanish-speaking/surnamed clients and encounter frustration or resistance are not likely to encourage the clients to return for treatment.

Therapists' Attitudes Regarding Mexican American Clients

Lorion (1974) finds detrimental attitudinal differences among middle-class therapists who tend to be more rejecting of low-income clients whom the therapists perceive as hostile, suspicious, crude and seeking only symptomatic relief. Furthermore, Lorion finds that the effectiveness of a therapeutic encounter involving a low-income client depends more on the therapist's personal characteristics than on his or her experience level or treatment approach. Padilla and his colleagues (LeVine & Padilla, 1980; Padilla, Ruiz & Alvarez, 1975) suggest that research results, such as those cited by Lorion, indicate that the personalismo (friendliness, warmth, sensitivity) extended by the therapist to the Mexican American client is essential to bridging the gaps between the two parties and to initiating a trusting relationship. Numerous authors (e.g., Chavez, 1979; Gomez and Cook, 1978; LeVine & Padilla, 1980; Szapocznik, Lasaga, Perry & Solomon, 1979) substantiate the importance of the therapist's personalismo, as well as hospitalidad (social graciousness) and dignidad (respect for the client) in establishing a positive therapeutic relationship with the Mexican American client despite cultural and class disparities. Buchanan and Choca (1979) also stress the importance of respecting the client's cultural etiquette during the delivery of mental health services.

The philosophical attitudes of the therapist toward the Mexican American client influence the nature of the therapeutic contact. Because most service providers are monolingual, Anglo Americans, they are de facto representatives of the dominant culture and may reflect the same insensitivities and prejudicial stereotypes about Mexican Americans that prevail in the majority culture. Bloombaum, Yamamoto and James (1968) studied clinicians' attitudes to determine whether the respondents held stereotypic notions regarding Mexican Americans. The results indicate that a stereotypic attitude regarding Mexican Americans does exist. Lopez (1977) attempted to identify the specific nature of any stereotypes to be found among a group of clinicians of various ethnic groups. Judged against Anglo Americans, the clinicians regard Mexican Americans to be more superstitious, more spiritually inclined, more family-oriented, more submissive, less aggressive, less independent, less practical, and less punctual. The reported stereotypes indicate that many therapists have preconceived ideas regarding the behavior of Mexican American clients which may be incompatible with therapeutic goals. This in turn may lead to the "self-fulfilling prophecy" that Mexican Americans respond poorly to therapeutic services because the service providers never expected the intervention to succeed.

Much of the potential effectiveness of mental health services is related to the degree of sensitivity and awareness possessed by the therapist with regard to the institutionalized racism experienced by Mexican Americans. In terms of limited economic, educational, housing and health care resources, the majority of Mexican Americans live within socially disadvantaged conditions. A failure by the therapist to recognize or appreciate the severity and enormity of these social and economic impediments sharply restricts the delivery of relevant, comprehensive treatment to troubled Mexican Americans. As noted by LeVine and Padilla:

> An effective therapist for Hispanics will have as a major goal the amelioration of personal distress caused by discrimination and institutional racism...The therapist cannot avoid the issues of prejudice and racism. If the therapist does not become a social advocate for the client when it is necessary, he or she is sanctioning, through neglect, continued discriminatory practices. (LeVine & Padilla, 1980, pp. 94-95)

Therapists' Roles in the Determination of the Treatment Process

The therapist's role in determining the nature of the intervention interaction is the final aspect of the clinician's influence upon the delivery of mental health services to Mexican Americans to be considered. Although the client clearly has a role in shaping the interaction, the service provider is largely responsible for assessing the nature of the client's difficulties, his/her needs and resources, and selecting an appropriate treatment modality in addition to determining whether additional supportive services for the client will be sought. These phases of the therapeutic encounter will be examined more closely in order to identify their impact upon the client and the outcome of the endeavor.

During the initial phase of treatment, the client-therapist relationship must begin to be established if the client is to be engaged in an extended treatment plan. The therapist's communications of personalismo and hospitalidad in a culturally sensitive manner are extremely important. The therapist is also involved, at this point, in responding to the concerns the client presents. Nonetheless, several authors (e.g., Chavez, 1979; Gomez & Cook, 1978; LeVine & Padilla, 1980) note the importance of la platica (conversation) in establishing a trusting relationship in which difficult issues can be addressed. The structured fifty-minute therapeutic hour, however, severely limits the therapist's ability both to interact personably with clients and to address their concerns, many of which may be perceived by them as crises.

Prior to beginning treatment, the therapist makes an assessment of the client's degree of adjustment or maladjustment to personal and societal circumstances. Burruel and Chavez (1974) recognize that serious treatment inadequacies related to diagnosis are based on the assumption that individuals from divergent sociological and cultural groups behave similarly when experiencing mental or emotional difficulties. The variation in cultural concepts of mental health and adaptation mechanisms necessitates considerable sensitivity on the part of the therapist evaluating a Mexican American client. LeVine and Padilla (1980) point out that the Mexican American folk-illnesses and healing processes, which could easily be misunderstood by a culturally insensitive therapist, can be viewed as allowing catharsis and introspection, two common components of treatment. The fact that an Anglo therapist may not be able to understand these phenomena in the cultural terms of the Anglo society does not diminish their validity and utility for Mexican Americans. As the two authors further note, Torrey (1973) recognizes that hearing voices, which is generally considered to be a hallucination and a symptom of psychosis, is more culturally sanctioned among Hispanic cultures and is, therefore, considered less pathological than in the Anglo culture.

LeVine and Padilla (1980) identify several factors which should be considered in assessing or diagnosing minority clients. For example, Mexican Americans differ in their perceptions of symptomatology according to their degree of acculturation and their primary language choice. When dealing with low-income Mexican Americans, one must also recognize that poverty compounds the cultural variation in symptomatology. It is possible that many symptoms expressed by Mexican Americans, such as anxiety, depression, withdrawal and physical complaints, are adaptive psychological responses and efforts to cope with the institutional racism of the majority culture and society. Prior to applying any diagnostic labels to Mexican American clients, the economic and social dimensions of the client's life must be evaluated along with personal, familial and cultural factors in order to assess accurately the individual's level of functioning.

The frequent utilization of standardized psychological tests and the heavy reliance upon the results of such instruments to assess clinically the Mexican American client is a problematic process. The administration of objective personality inventories, projective personality instruments, and intelligence tests can lead to a distorted understanding of the Mexican American client if the cultural biases in such tests are not acknowledged. Wright and Isenstein (1977) report that traditional tests have been criticized as invalid instruments for either measuring the abilities of minorities or for predicting their functional capabilities in academic or real-life situations. According to Anastasi (1976), tests are unlikely to be equally "fair" to dissimilar cultural groups, and cross-cultural tests have diminished, but not eliminated, cultural differentials in test performance. Padilla and Ruiz (1975) also contend that cultural differences among subjects and test contents influence tests responses such that inaccurate results are obtained. For example, the translation of tests for Spanish-speaking minority subjects does not eliminate biased middle-class concepts contained in tests. Furthermore, the cultural variables of language, willingness to self-disclose, incentive style, and problem-solving approaches are among the emotional and motivational factors that limit the validity of test results for the purposes of diagnosis and treatment-planning for Mexican American clients. The effects of differences in ethnicity, language and socioeconomic status between the examiner and subject upon test outcomes have been inconclusively questioned and merit additional empirical research (Olmedo, 1977).

Overall, the psychological testing and evaluation process is influenced by differences in class, language and ethnicity between the subject and examiner, as is the treatment relationship between the client and service provider. Padilla and Ruiz (1975) caution against the determination of a treatment plan based solely on test results that may not reflect the Mexican American client's potential to engage in meaningful therapeutic services. The same cultural consideration is necessary if misdiagnosis of Mexican American clients based on invalid psychological test results is to be avoided.

Until further studies permit the development of a diagnostic nomenclature sensitive to Hispanic cultural issues, LeVine and Padilla (1980) recommend that the client's degree of maladjustment be evaluated as it affects the client's adaptation and functioning in his/her preferred cultural mode. In doing so, the traditional psychodynamic evaluation is broadened to include assessment of the interaction between sociological/environmental factors and the psychological dynamics of the individual. This orientation recognizes the intrapsychic/extrapsychic dimensions of stress delineated by Ruiz (1977) and serves as a precursor to establishing a comprehensive, potentially meaningful treatment plan. This approach would also eliminate the likelihood of misdiagnosis of Mexican American clients and prevent them from being labeled inappropriately as severely disturbed or intellectually limited.

TREATMENT APPROACHES UTILIZED WITH MEXICAN AMERICAN CLIENTS

The literature reports a wide range of therapeutic approaches that may be applied in working with Mexican Americans. Much uncertainty still exists as to which treatment approaches are most effective, due to the heterogeneity of Mexican American service recipients. Several major considerations in designing services will be reviewed briefly.

Psychotherapeutic treatment is characteristically non-directive, and stresses the client's development of insight into psychodynamic processes through verbal interchanges with the therapist. The applicability of these methods and goals has been questioned with regard to low-income clients who are not experienced in engaging in this type of verbal activity with a culturally different therapist.

Lorion (1973) states that individuals from lower socioeconomic levels who seek mental health services prefer advice and resolution rather than reflection upon intrapsychic processes. Cobbs' study (1972) of treatment expectations also notes that low-income patients prefer that therapists assume active, directive roles rather than a passive attitude.

Acosta (1977) summarizes the results of Albronda, Dean and Starkweather's research in the 1960s which presented a different view of the low-income client engaged in psychotherapy. Their study concludes that low-income patients respond better to individualized therapy than the high-income patient group. Acosta infers that the belief that low-income clients do poorly in psychotherapy may reflect discriminative attitudes held by therapists rather than any innate conflicts or inadequacies among economically disadvantaged populations and the psychotherapeutic process. Commenting on his own experiences of delivering mental health services to Mexican American clients, Acosta concludes:

> I have seen a highly positive response from both men and women to the opportunity to participate in Spanish-speaking therapy. Rather than stereotypical poor time orientation and low self-disclosure styles, patients have typically shown high reliability in keeping appointments, once they are involved in treatment and have self-disclosed a great deal in therapy. This pattern has been the norm in crisis intervention, time-limited or short-term therapy, long-term therapy, and group therapy. (Acosta, 1977, p. 226)

In order to alleviate the perceived incompatibilites of psychotherapeutic interventions, several authors have promoted the application of directive, behavioral approaches to working with Mexican American service recipients. Ruiz, Casas and Padilla (1977) developed a behavioral therapeutic approach that is directive as it focuses upon concrete, immediate, goal-oriented interventions by the therapist. Casas (1976) advocates a behavioral approach that is flexibly oriented so as to direct therapeutic attention to either the client or the environment. Boulette (1976a) finds behavioral assertion training techniques to be well-received and effective with low-income depressed Mexican American women.

A directive behavioral therapeutic approach is well-suited to meeting the needs of many Mexican Americans. As Chavez (1979) reports, approximately one-third of the clients her research surveyed regarding their therapeutic expectations expressed a desire for direccion in terms of guidance, answers or suggestions from the therapist. A random sample of Mexican Americans in Lubbock, Texas was surveyed by Mack, James, Ramirez and Bailey (1974) to determine their attitudes toward therapy (LeVine & Padilla, 1980). The results indicate a preference for a directive therapist who would define the client's problem and be emotionally nurturing.

Although both the non-directive psychotherapeutic approach and directive behavioral treatment styles have been validated among certain groups of Mexican Americans, it would be premature to state that either approach is consistently more effective or appropriate for use with all Mexican Americans. In a comparison of the "therapeutic listening" treatment approach with "behavioral rehearsal" methods, Boulette (1976b) reports that neither approach is consistently effective with a population of low-income Mexican American women. In order to determine which approach is best suited to a Mexican American client, LeVine and Padilla (1980) recommend that the client's needs and attitudes regarding direction and therapeutic style should be heeded, lest the client-therapist relationship be reduced to an unproductive power struggle.

Nevertheless, in spite of the heterogeneity of the Mexican American population and their varied individual needs for services, several generalizations can be made regarding the establishment of a viable, productive, therapeutic contact with Mexican American clients. Initially, the therapist must recognize this population's diversity and eliminate any of the pre-existing cultural stereotypes that could deter the therapeutic interaction. A genuine concern and empathy for the individual Mexican American client and his/her environmental circumstances should be communicated in order to reduce the cultural distance that generally exists between the client and the service provider. Very specific attention should be addressed to assessing the client's bond to his/her family and facilitating the involvement of the extended family in the therapeutic process if appropriate. The Mexican American family system, which generally is strongly linked together, can then serve as a therapeutic collaborator in treating the client rather than resist the therapeutic goals due to a lack of information and understanding.

In addition to assessing and planning the role of the Mexican American client's family in the treatment process, several other basic interview issues ought to be addressed by the therapist. All interventions should take note of the client's cultural identification and socioeconomic level, as well as the community resources available to enhance the client's economic position if needed, in addition to responding to the client's expression of symptoms (LeVine & Padilla, 1980). These latter recommendations support the concept that a culturally sensitive therapist encourages the client to play an active role in setting treatment goals, but is flexible enough to respond to the client's immediate needs, even if these involve the provision of directive services or economic relief via tangible social services.

Conclusion

The preceding review of research reports and literature regarding the basic elements of the treatment intervention is presented in order to acquaint the reader with the four major interacting elements that are involved in the delivery of mental health services.

The four components of the treatment process include the cultural context within which services are designed and delivered, the service recipient and the nature of the latter's problem or need, the service provider, and the treatment approaches implemented. The interactions of these elements create a treatment system that can best be adapted to the needs of the Mexican American community when the roles and characteristics of each element are fully understood. Many major issues relevant to the delivery of appropriate mental health treatment to Mexican Americans (such as the need for bilingual/ bicultural services or the inherent fallacy in translating treatment approaches founded upon Anglo American cultural belief systems) have only been outlined.

Additional research is needed on the interaction of the four elements in bilingual/bicultural service programs as well as evaluative documentation of successful programs of this type. Other important issues to be researched regarding the implementation of bilingual/ bicultural programs include affirmative action programs to recruit bilingual/bicultural staff at CMHCs, inservice training of CMHC staff in Spanish and about multicultural issues, and the existence of culturally relevant curriculum in the psychiatry, psychology, social work and nursing education programs. Several bilingual/bicultural service models reported in the literature are reviewed within the following chapter.

CHAPTER III

TREATMENT MODELS DEVELOPED FOR USE WITH MEXICAN AMERICANS

The gradually increasing number of Mexican American scholars and culturally sensitive service deliverers in the mental health field has led to the production of a growing body of literature regarding the appropriate delivery of services to Mexican Americans. Numerous treatment models concerning services to Mexican American individuals have been developed and reported.* Although this monograph does not include an exhaustive survey, a range of behavioral, organizational, and general bilingual/bicultural treatment models are reviewed in order to familiarize the reader with alternative treatment designs. The models deal with the establishment of a therapeutic context (via organizational structure and treatment approach) that the Mexican American client will find culturally compatible, thus maximizing the likelihood of therapeutic gain by the client.

Bilingual/Bicultural Treatment Approaches

Frequent references to bilingual/bicultural services are found among the treatment literature produced by Hispanic academicians. It is hardly possible to overemphasize the importance of bilingual/bicultural therapeutic resources (clinicians, support staff, and written prevention and education materials) in the delivery of effective services to Mexican Americans. As was noted earlier in this monograph, numerous researchers have recognized the obstacles created by cultural differences and/or linguistic incompatibilities in the creation of a therapeutic bond between mental health service deliverers and recipients.

---

*"Model" is used here to denote a conceptual design for the delivery of mental health services.

Simply stated, the communication that is fundamental to the therapeutic process is impossible without a mutual language. Shared language alone, however, does not insure a positive therapeutic outcome. Without sensitivity to the cultural aspects of the client's linguistic patterns, cognitive style, and overall life circumstances, language becomes a mere chain of words within which the emotional content of the verbal interaction is lost. Of equal importance are the non-verbal interactions that occur within therapeutic relationships. Without an understanding of the culturally unique aspects of non-verbal exchanges, a great deal of miscommunication and misinterpretation is likely to occur.

The effective therapeutic encounter is a culturally influenced experience that does not automatically transcend cultural boundaries. Consequently, Mexican American service recipients who speak either Spanish, English, or both, and who also exist within two cultural milieus must be treated by service deliverers who can competently move within both the traditional and the more bicultural ranges of the Mexican American cultural and linguistic realms.

Several authors have questioned what constitutes an adequate bilingual/bicultural treatment approach. Gibson (1975) emphasizes the importance of cultural nuances and addresses the inadequacies of merely translating English concepts into Spanish when working with Mexican Americans. Gomez and Cook (1978) note that a translation of extant therapeutic methods, without any culturally sensitive revisions in approach or content, skirts the issue of whether the Anglo-oriented treatment approach is fundamentally compatible with the Mexican American client's philosophical outlook and needs. Souflee's response (1974) to the issue involved the development of a bicultural training curriculum which addresses the need for the development of bicultural sensitivity among mental health workers.

Padilla, Ruiz & Alvarez (1975) report three alternative models for the delivery of mental health services to Mexican Americans that incorporate bilingual/bicultural treatment considerations. These three models are identified by Padilla and his colleagues as the professional adaptation model, the family adaptation model, and the barrio service center model. The components of each model will be discussed briefly.

The professional adaptation model calls for revisions and adaptations among the staff and services of mental health centers serving Spanish-speaking populations. Brief accounts of centers established in East Los Angeles (Karno & Morales, 1971) and Denver (Phillipus, 1971) illustrate changes made in staffing patterns, service philosophy and treatment programs which were intended to enhance the compatibility and applicability of services to the Mexican American community in which centers were located. The outstanding attribute of service programs adhering to this model is their willingness to set aside established, frequently rigid concepts of treatment in order to allow Mexican American recipients to act as definers of the service structure through their participation in the treatment programs.

The family adaptation model is predicated upon the strong, culturally based, active role of the Hispanic family in emotionally supporting its members. Padilla discusses a group treatment approach originated by Maldonado-Sierra and Trent (1960) which calls for the group leaders to play traditional familial roles prevalent in Puerto Rican culture. Although the effectiveness of this specific approach has not been documented with Mexican American clients, it is distinguishable for its unique emphasis on culturally defined interaction patterns within a group treatment process. The potential effectiveness of such an approach has been alluded to by Giordano and Giordano (1976) who assert that the impact of ethnic similarity among therapeutic group members is an influential but unacknowledged treatment dynamic. The effectiveness of the family adaptation model is dependent upon the bilingual/bicultural capabilities of the treatment staff. As such, it has limited applicability in most mental health centers since they are disproportionately understaffed with regard to Mexican Americans.

The final alternative model identified by Padilla, Ruiz and Alvarez is the barrio service center model. Four illustrations of centers located within either Puerto Rican or Mexican American communities are cited. The basic philosophical attitude regarding mental health services prevalent among barrio service centers is the belief that numerous supportive social services, as well as mental health treatment services, must be offered if the comprehensive mental health needs of Hispanic clients are to be met. The barrio service center model embodies the spirit of community mental health rather than merely treating mental illness.

Abad, Ramos and Boyce (1974) document a positive response to mental health services by Hispanics following the implementation of another bilingual/bicultural service model in Conneticut. Abad et al.'s model calls for a community-based center to offer walk-in or scheduled services including clinical, social service, preventive and indirect community-oriented interventions. In order to incorporate the community into the service planning and delivery process, the model emphasizes the use of indigenous paraprofessionals, as well as the early establishment of strong ties between the mental health center and both the informal and formal networks of community leaders. In recognition of the many needs experienced by the majority of ethnic service recipients, the model advocates discarding the traditional model of psychiatric services and instead broadly defining the mental health service concept in order to legitimize the requests of many clients for both therapeutic and non-clinical assistance.

The pluralistic therapy design developed by LeVine and Padilla (1980) for cross-cultural interventions with Hispanic clients is an additional model that emphasizes bilingual and bicultural aspects of service delivery to Mexican Americans and other Hispanics. Pluralistic therapy is treatment that recognizes the cultural context of the client's beliefs and behaviors, focusing on the functional adaptation by the client to the cultural milieu of his/her choice. Fluency in Spanish on the part of the therapist working with Spanish-speaking or Spanish-dominant clients is seen as vital in understanding and communicating with the Hispanic client.

The pluralistic therapy model calls for the service deliverer to be aware of the points of contact and conflict between ethnic minority and majority groups. Of particular importance is the therapist's recognition of institutionalized forms of racism and oppression that undermine the mental and emotional well-being of Hispanics and negatively influence their responsiveness to mental health services offered in accordance with the dominant "medical model." The medical model of mental health treatment, which posits a psychodynamic view of mental illness, is thus replaced by a social action orientation that includes as appropriate roles for the therapist those of advocacy for clients and of working to reduce oppressive and discriminatory social conditions.

The diagnostic and treatment methods promoted by LeVine and Padilla are sensitive to culturally sanctioned norms of illness and health. The pluralistic therapist assists the Hispanic client in clarifying his/her therapeutic goals in order to facilitate the client's positive adjustment to the preferred culture/s. Other important cultural variables in treatment, such as the role of the family, reference to folk illness and treatment, emphasis on religion, the nature of the symptomatology expressed by the client, and the manifested degrees of cultural etiquette, such as respeto and dignidad, vary among clients and are introduced when necessary in the pluralistic therapy process. Rather than adhering to a specific treatment modality or structured interview format, the culturally sensitive pluralistic model recommends the selection of a modality based upon the client's needs and goals. The pluralistic model structures flexible interventions around the nature of the client's problems rather than the 50-minute therapeutic hour, thus allowing adequate time for individualized treatment or crisis intervention services when needed. This necessitates a supportive institutional context that recognizes the need for flexible service arrangements if the cultural integrity of Mexican Americans is to be maintained.

The pluralistic therapeutic model has several attributes that maximize its applicability to large numbers of Mexican American service recipients. It recognizes the heterogeneous nature of cultural lifestyles found among Hispanics and ascribes no qualitative values to either bicultural or traditional cultural adaptations. The needs of the client are the primary concern, whether these are for tangible economic assistance or for introspective psychotherapy. Overall, the model's inherent flexibility on the part of the therapist and client, as well as its recognition of the necessity of bilingual/bicultural services in working with Hispanics, accentuates its potential applicability with Mexican Americans.

Behavioral Models

Earlier in this monograph, the issue of whether behavioral treatment approaches or psychotherapeutic treatment methods were more suitable for Mexican American clients was addressed. It appears that too little empirical evidence is available to assess definitively the merits and effectiveness of different treatment methods in differing circumstances. Several Mexican American mental health practitioners, however, have reported favorable therapeutic results with behavioral approaches and have developed treatment models to be used with Mexican American clients. Four behavioral treatment models reported in the literature will be summarily discussed.

Low-income Mexican American women are reported by Boulette (1976a) to be responsive to behavioral interventions, such as assertiveness training, role modeling and behavior rehearsal. Boulette maintains that the oppressive social and economic conditions experienced by low-income Mexican American women result in psychological disturbances that can be treated by behavioral techniques which reduce the clients' typically sub-assertive behavior patterns. The model emphasizes increasing the female client's coping and adaptive behaviors, as well as her understanding of her role in establishing a more satisfying lifestyle. Boulette notes the importance of the therapist's sensitivity to and utilization of cultural variables in guiding the behavioral intervention.

A behavioral model suitable to Mexican American clients is proposed by Casas (1976). An open, flexible therapeutic framework that can focus the change effort upon either the Mexican American client or the detrimental environmental factors affecting the client is considered by Casas to be particularly relevant. If internal changes are desired by the client, the therapist may address behavioral, cognitive or emotional patterns in the treatment plan. If, however, the difficulties affecting the client are occurring in the client's environment, Casas recommends that the therapist serve as a role-model to the client in working to promote the desired social changes. Because the principles of behavioral treatment are derived from the areas of social psychology, learning psychology, and experimental psychology, Casas suggests that the proposed model is likely to be less culturally biased and, therefore, suitable for Mexican Americans.

Herrera and Sanchez (1976) report a behaviorally oriented group treatment approach they use with Spanish-speaking, lower class individuals. The authors maintain that due to the inadequate number of trained Mexican American practitioners and the large number of Mexican Americans who indicate positive attitudes toward treatment, a multi-faceted group approach allows the best utilization of culturally compatible Mexican American practitioners by a greater number of Mexican American service recipients. Following individual behavioral analyses to determine each member's treatment goals, problem-oriented, behavioral treatment groups are held weekly. The group format offers a social skills lab experience for the members as well as building a support system. Herrera and Sanchez, who report positive results in terms of group attendance and treatment outcome, recommend further study in the application of group behavioral treatment with low-income Mexican Americans.

A culturally relevant behavioristic model for counseling Mexican American college students was conceptualized by Ruiz, Casas and Padilla (1977). Developed to address the underutilization of collegiate counseling services by Mexican Americans, the model distinguishes between the needs of Mexican American students that require bilingual/ bicultural services and those problems that are not culturally related. The behavioristic model emphasizes cognitive restructuring, behavior rehearsal, and role-modeling as directive approaches to be followed. The model calls for a bilingual/bicultural therapist who is comfortable in and familiar with the Mexican American student's native environment as well as the academic setting. Cultural sensitivity in applying behavioral techniques, such as assertive behaviors within the Mexican American family, is stressed by the authors. Despite the fact that Ruiz's model originated to meet the special needs of Mexican American college students, the suggested procedure for the determination of the degree of cultural emphasis in the treatment plan has potential applicability for a wide range of Mexican American clients.

Organizational Models

In an effort to increase Mexican Americans' utilization of mental health services, practitioners and scholars note a need for alternative organizational contexts in which to deliver appropriate and accessible services. As Gomez and Cook (1978) state, the fact that treatment approaches are determined by institutional policies, which may not recognize the needs of service recipients, makes it possible to deliver irrelevant services to Mexican Americans in either Spanish or English. Accordingly, the authors conclude that effective services can best be rendered to Mexican Americans if mental health centers would replace traditional psychodynamic models with socio-cultural intervention models and flexible organizational procedures that allow the integration of alternative service schemes.

Several organizational features of La Frontera, an out-patient clinic operating in Tucson, are described by Heiman, Burruel and Chavez (1975). In addition to staffing the center with a significant number of bilingual personnel, half the membership of the board of directors is Mexican American. High rates of services utilization are reported, which are presumably due to the cultural compatibility between the administrative and treatment staffs with the Mexican American clients being served. This suggests that ethnic representation at policy-setting management levels of community mental health centers increases the likelihood of enacting organizational practices consistent with the needs of ethnic client populations.

Chavez (1978) identifies other organizational aspects of La Frontera that she groups under the heading of a responsive model of service delivery. As previously noted, the staff and board of directors of the agency have significant proportions of Mexican Americans. Rather than predetermining the range of services to be offered, La Frontera places great emphasis on delivering services in a manner responsive to the acute social and economic needs of the target population. In addition to therapeutic services, also offered are a Warmline telephone intervention program, a well-baby clinic, a preschool, children's services, community outreach and advocacy, education and consultation services, and rural services. The center also maintains a policy of responding to whatever request for assistance or information the potential service recipient makes of the agency rather than defining some requests as inappropriate. Community service workers are also utilized to assist in the provision of tangible social services. By making these efforts, the agency establishes the credibility of its service intent and usefulness in the local community. As a result of its efforts, Chavez reports that the center's Mexican American clients average 6.8 visits to the center for treatment while Anglo American clients average 7.5 visits.

The existence of an outreach component is important in a responsive organizational model of delivery. Utilization of media coverage of available mental health services is a significant feature of the La Frontera organizational model described by Heiman et al. Szapocznik et al. (1979) report unanticipated high levels of success in interesting elderly Hispanics in mental health services as a result of a mass media campaign which publicized the availability of services in Florida. LeVine and Padilla (1980) also note the importance of an outreach component in an organizational system attempting to serve Hispanics.

The final organizational model to be considered is the neighborhood based mental health model explicated by Owan (1980). Briefly stated, the neighborhood based mental health concept promotes the design and staffing of innovative mental health programs along ethnic-specific minority lines in order to assure that the Five A's (Accessibility, Availability, Appropriateness, Acceptability and Accountability) will be satisfied with respect to the types and quality of services offered to minority citizens. Described as a complementary service system to existing CMHCs, neighborhood based mental health services are proposed to serve discrete ethnic neighborhoods rather than the entire population of a community. With such specificity, proponents of neighborhood based mental health assert that the Five A's can be met more adequately with regard to ethnic communities that have remained underserved by the existing community mental health movement.

Conclusion

The preceding models were presented in order to acquaint the reader with alternative models of service delivery that have been developed to address the needs of Mexican American clients. Although no one model has been discussed in detail, collectively they illustrate the varied cultural, treatment and organizational frameworks that could be used to structure service programs for Mexican Americans. A common feature in most of the models reviewed is the need to acknowledge innovative service delivery frameworks.

The following chapter presents an additional alternative service design conceptualized by the author. Developed with an awareness of the fiscal and administrative constraints faced by CMHCs, the alternative framework attempts to reapportion existing CMHC staff positions and roles in order to facilitate the delivery of quality bilingual/multicultural treatment services within the context of CMHCs.

CHAPTER IV

A TREATMENT TEAM: AN ALTERNATIVE APPROACH TO THE DELIVERY OF MENTAL HEALTH SERVICES TO MEXICAN AMERICANS

The delivery of comprehensive community mental health services is a large and complex task due to the interplay of the numerous factors contributing to an individual's mental health and well-being. When a sizeable proportion of an ethnic target population experiences the injustices and inequities of a prejudiced dominant culture, as is true of Mexican Americans, the task of meeting that population's mental health needs becomes even more challenging. With this in mind, it is necessary to develop and apply all the mental health system's resources in the most creative, productive and advantageous manner possible. An alternative treatment approach, which will be referred to as the treatment team approach, is offered by the author with the goal of maximizing the therapeutic potential of a mental health center's interaction with Mexican American service recipients.

The treatment team approach involves the pairing of a clinically trained staff member, who offers diagnostic and therapeutic services, with an indigenous worker representative of the target community, who engages in client advocacy and supportive services. This approach is founded upon the assumption that offering the Mexican American client both therapeutic and supportive services in relation to the client's individualized needs and resources is necessary if mental health needs are to be met. It further assumes that collaboration between mental health workers with a diversity of specialized skills, knowledge and experience strengthens the service network. The treatment team approach is discussed following a review of the literature regarding the use of paraprofessionals in mental health settings.

The Role of Indigenous Community Workers as Seen in the Literature

The concept of employing community workers to enhance mental health services is by no means unique. Numerous scholars have written about the importance and usefulness of indigenous community workers, such as mental health agents, family health aides, or paraprofessionals, as they are usually identified, in serving ethnic clients. Giordano and Giordano (1976) reason that indigenous workers are well-acquainted with the norms determining culturally acceptable behavior and thought within their community. The research results of Lorion (1974) indicate that a therapeutic match between a mental health worker and client of similar race and socioeconomic background facilitates effective use of the treatment process by the service recipient.

Padilla, Ruiz and Alvarez (1975) maintain that the use of paraprofessionals in mental health centers enhances the agency's image in the Mexican American community. Bilingual/bicultural indigenous workers can also reduce the large "cultural distance" gap that often exists between low-income Mexican American clients and the majority of helping professionals, who are middle-class Anglo Americans. Although the acute shortage of Mexican American mental health professionals is a critical deficiency that must be alleviated, indigenous community workers are valuable service resources for meeting immediate needs.

Gomez and Cook (1978) state that the services provided by the paraprofessional worker may, in many instances, be more meaningful for the Mexican American client who may not recognize the utility of a long-term psychotherapeutic process without tangible, supportive intervention. However, given exposure to the range of therapeutic services available and having established a positive atttitude about the center after receiving some supportive services, more low-income Mexican Americans may begin to regard mental health services as relevant and meaningful. Treatment results reported in the literature support this concept. For example, a Spanish-speaking short-term group therapy program conducted by bilingual paraprofessionals is reported by Normand, Iglesias and Payn (1974) to be very successful in responding to the immediate needs of clients. The group process also facilitates the continuation of over half the group participants into longer, more intensive psychotherapeutic treatment. The authors reason that the short-term group offers its members a sense of immediate emotional gratification and support, as well as expanding their awareness of psychological processes that could later be capitalized upon in continued treatment.

Other authors elaborate upon the diverse roles fulfilled by community workers. Through the use of indigenous nonprofessionals, networks of comprehensive mental health services including innovative ancillary services are being successfully implemented. Among the services performed by indigenous workers in a successful New York City program are: (1) expediting services offered by other programs on the behalf of clients, (2) serving as a friend-in-need to clients, (3) assisting clients in becoming active participants in local community affairs, and (4) organizing community self-help or action programs (Hallowitz, 1968). Paraprofessionals have also been reported by Levine (1970) as being involved with either individuals or community groups in mental health intervention processes directed toward the provision of immediate needs, problem and conflict resolution, and the implementation of changes in existing community systems.

Herbert, Chevalier and Meyers (1974) report very positive results from the usage of indigenous workers at a community mental health center in Harlingen, Texas. The indigenous workers perform a variety of casework tasks, including (1) counseling, (2) medication supervision, (3) follow-up, (4) transportation, (5) intake, (6) case staffing, (7) referrals, (8) day-center work, (9) patient evaluation, (10) public information and education, (11) community support, (12) outreach, (13) recording, and (14) participation in inservice training. The study conducted by the three authors examines the auspices under which the program was developed. Outcomes reveal that a highly flexible role structure is designed by the program planners in order that each paraprofessional can maximize his or her personal skills. The novel nature of the program also restricts the planners from rigidly outlining the service format to be followed by indigenous workers.

In addition, the innovative program corresponds with a number of favorable service results, including reduced readmission rates to the local state hospital and an increased volume of services distributed both in numerical terms and with regard to geographical distribution. The program is reportedly well-received by the majority of the parties involved in the program, including the National Institute of Mental Health, the Texas Department of Mental Health and Mental Retardation, the center's professional staff, community advisory boards, and the paraprofessional participants.

Although extensive literature has been produced regarding the use of mental health paraprofessionals within the mental health service system, much of it reiterates the roles and viewpoints briefly reviewed. Not all the writing in the area, however, documents favorable indications regarding the utilization of indigenous workers. Andrade and Burstein's (1973) empirical assessment of ethnic clients' preferences for either professional or paraprofessional workers does not support the popularized concept that minority clients find indigenous paraprofessionals to be more empathic or helpful than professionals. Early research in the area of paraprofessional effectiveness found that some service recipients resisted being seen by an indigenous worker, preferring the credentials and presumed expertise of professionals to the cultural familiarity of indigenous service providers.

The Treatment Team Approach to Mental Health Services

The treatment team approach was formulated recognizing both the reported positive and unfavorable attributes related to the use of indigenous mental health workers, as well as the numerous criticisms regarding the ambiguous effectiveness of psychotherapeutic services. By making accessible to the ethnic client both the professional and paraprofessional members of the treatment team, each client's opportunity to receive relevant mental health services is maximized.

This approach allows both the clinical staff member, who is usually a social worker or psychologist, and the indigenous community worker, a Mexican American paraprofessional or baccalaureate level employee who is an established resident in the community, to play necessary and unique roles in the delivery of community mental health services. Although psychiatrists provide the necessary medical treatment and diagnoses for numerous clients, clinical staff are usually responsible for additional client assessments and implementation of treatment plans through the use of various therapeutic modalities. Clinical staff members bring to the treatment team the experience and skills developed in clinical training, which are necessary attributes of suitable mental health care. Because the clinical professionals are generally trained and recruited from academic settings away from many areas where community mental health services are located, clinical staff members often lack familiarity with existing social services resources, health care services, educational systems, and numerous other components of local community culture which impact upon the client.

The indigenous community worker's expertise is based upon his/her knowledge of the Mexican American barrio and the lifestyles of fellow Mexican American residents. Due to a familiarity with the community, the indigenous paraprofessional is capable of serving as a liaison between center staff and the target population to be served. In addition to transmitting community input to a center's administrative and treatment staff, indigenous community workers can serve as resources in program planning efforts, thereby increasing the likelihood of compatibility between the needs of residents and services offered by the center. Due to cultural similarity with the target population, the indigenous community worker can frequently serve as a more appropriate role model to clients than the clinical staff member who too often is ethnically and socioeconomically dissimilar from the Mexican American service recipient.

Although the indigenous community worker may function as a translator for monolingual Spanish-speaking clients within certain community service networks, the paraprofessional is not intended to serve as an interpreter for the treatment team. The team approach in no way minimizes the need for bilingual/bicultural clinicians who should be able to relate independently to monolingual or bilingual, Spanish-dominant clients in a culturally sensitive manner if the clinical tasks of assessment and treatment are to be adequately completed. Neither is it appropriate that complex clinical and treatment needs of Mexican American clients be left only to the indigenous paraprofessional because no bilingual/bicultural clinical professionals are available at community mental health centers. The treatment team approach calls for just what the name implies -- two specialists working together to deliver comprehensive, culturally compatible mental health services to Mexican Americans. Other advantages of the treatment team approach for the delivery of services to Mexican American clients will be explored.

Favorable Therapeutic Factors Associated with the Treatment Team Approach

The proposed alternative design for the delivery of mental health services enables the provision of services that are responsive to the mental health and social service needs of the Mexican American community. Although the treatment mode conceivably is conducive to a wide range of client populations, only its application to Mexican Americans will be considered.

In addition to allowing both mental health professionals and indigenous community workers to fulfill the necessary roles identified earlier, the treatment team approach is an organizational design that promotes a number of potentially favorable treatment factors in different aspects of mental health service. Specifically, the therapeutic intervention process involving the client, the planning and program design process and the interface between the mental health center and the community can all be enhanced by the team approach.

Initially, the therapeutic intervention process is expanded to allow interaction between the service recipient and two service providers, rather than the typical one-on-one design traditionally followed. Consequently, many of the positive effects associated with treatment are multiplied. The client may receive twice the amount of empathic caring and human responsiveness available from one worker. The client also doubles his/her opportunities to rehearse and develop new behaviors, attitudes and social skills within the context of two supportive relationships. As the treatment team flexibly allows the clinical professional and indigenous paraprofessional to work either conjointly or individually with the client, the potential for the client to receive more intensive service time in terms of staff personnel-hours also exists within this framework. The increased availability of services is particularly meaningful in situations where intensive, crisis-oriented care is required, as is often true of low-income Mexican American clients who are experiencing multiple problems. The involvement of two mental health workers with a particular individual or family increases the likelihood of a prompt response to emergency situations needing immediate care.

Diagnostic procedures and treatment planning can also be enhanced by adopting the treatment team approach. Rather than relying solely on assessments made during clinical contacts, observations made by the indigenous community worker of the client's social skills and functional capabilities while working in the community could be relayed to the clinical staff member and thus could constitute an important contribution to the assessment process. The treatment process can be designed to focus upon the resolution of either intrapsychic or extrapsychic problems (as defined by Ruiz, 1978) in relation to the client's needs. The degree of involvement of the clinical professional and the indigenous community worker would be flexibly determined, based upon the problems presented by the service recipient, but both members of the team would be accessible to each client, although perhaps involved in different degrees of service delivery. Both types of services would generally be needed by Mexican American clients, the majority of whom experience adverse socioeconomic conditions which predispose psychological adjustment stresses.

The flexibility of the treatment team approach gives the client considerable latitude in dealing with sensitive and/or serious personal issues with either the indigenous paraprofessional, with whom the client may feel a bond of cultural identity, or with the clinical professional if interface with a credentialed person is preferred. As Torrey's work (1973) emphasizes, the expectations the client holds regarding who can effectively treat the problem are important. Whether the client believes his/her needs would best be met by the academically credentialed professional or the "street-wise" paraprofessional, both would be accessible to the client within the treatment team approach.

Involvement of a client's family in the therapeutic process can also be facilitated by the treatment team approach. Together the clinical staff member and the indigenous community worker can address the special circumstances and needs of the familial environment in order to promote a positive therapeutic outcome on the part of the client. The availability of both staff members affords the same benefits to the family system as were previously noted regarding the client. Intervention within the client's environment via the integration of the family into treatment is frequently necessary due to the multiplicity of problems experienced by many low-income Mexican American families. An increase in the effectiveness of the center's intervention efforts would be likely to occur if both the Mexican American client and his/her interaction with the environment are addressed by both the clinical staff member and the indigenous community worker.

Ideally, an open exchange of information would exist between the team and client so that all members would be informed of issues and developments occurring during therapeutic or supportive contacts. Such a policy of open exchange of information would also allow the paraprofessional to serve as an interpreter for the client or his/her significant others, should such a need arise, without the breach of confidentiality that violates the client's privacy when extraneous staff are brought into therapeutic or diagnostic sessions to translate.

The team can also facilitate the delivery of mental health services to Mexican Americans in two additional vital respects. The supportive services delivered by the indigenous paraprofessional to meet immediate needs may allow the clinical professional to "buy enough time" to allow the client to experience the utility of therapeutic interventions and consequently become engaged in a different caliber of treatment. Furthermore, the indigenous community worker may facilitate therapeutic treatment by aiding the client with transportation resources that enable the client to attend therapeutic services that would otherwise be unaccessible.

The center's planning and program design process would be enhanced by the feedback of the treatment team regarding service needs. The deployment of indigenous community workers within the community would enable the identification of previously neglected service needs and ideally reduce the gaps between the types of services offered and the types of needs being experienced by local residents. If, for example, an emphasis has been placed on aggressively reducing the readmission rates of previously institutionalized persons, the indigenous community worker and clinical staff member could offer valuable information regarding the availability of a social support structure for such clients, as well as the design of a continuity-of-care therapeutic program.

Mexican American proponents of the use of indigenous mental health workers, such as Gibson (1975) and the collaborative work of LeVine and Padilla (1980), emphasize the importance of a reciprocal exchange of ideas between mental health professionals and indigenous community workers if the full benefit of the latter's expertise on local culture and community operations is to be derived at the program planning level. Gibson further points out that such interchanges could promote the breakdown of stereotypic barriers erected by many Anglo American professionals that restrict and impede the quality of services delivered to Mexican Americans. Gomez and Cook (1978) support the concept that indigenous workers must be fully integrated into the center's service planning process.

Lastly, the interface between the mental health center and the community can expand and become more viable as a result of the work of the treatment team. The team's work at both the therapeutic and supportive levels has positive implications for establishing a strong, interactive services network with health care, educational, legal, recreational, employment, ministerial and community support services. The coalitions built between the indigenous community worker and other service networks may enable the paraprofessional to serve as a particularly potent advocate for center clients.

The indigenous paraprofessional's work within the community may enable him/her to function as a catalyst in community self-help efforts or barrio advocacy endeavors, thereby making more credible the center's role in responding to the needs of average citizens in community affairs. The indigenous paraprofessional's exposure within the barrio would serve as a public relations campaign within the Mexican American community, as well as illustrating the center's willingness to "hit the streets" to meet the needs of local residents within their environments. The delivery of supportive mental health services by indigenous community workers to Mexican Americans within the barrio also addresses the earlier failures of community mental health services being inaccessible to Mexican Americans.

The indigenous paraprofessional can serve in the dual capacity of outreach worker and public information disseminator by providing barrio residents with public presentations or group sessions dealing with topics of mental health education and prevention. As a result of such contacts, the indigenous community worker could acquaint residents with the center's purpose and functions as well as facilitate contact with the agency. Furthermore, serious disturbances that have gone untreated may be noticed and pursued upon an outreach basis.

The conceivable benefits of the treatment team approach, with its incorporation of the indigenous paraprofessional into the therapeutic alliance, are merely speculative at this point. Prior to assessing the utility of such an approach, it must be implemented within a community mental health center service system. Several considerations involved in the implementation of this approach will be discussed briefly.

Applicability of the Treatment Team Approach to the CMHCs and Mexican American Clients

In the final analysis, no conceptual design of treatment services is meaningful unless it has the potential for realistic application. Implementation of the treatment team approach is conceivable, but would require several adaptive changes to be made on the part of a community mental health center's operations and philosophical foundations.

The introduction of the treatment team approach would require, in many instances, conceptual revisions regarding the nature of mental health treatment (whether it is to be narrowly or broadly defined) and the purpose and intent of community mental health centers. If mental health problems are defined very narrowly, it is likely that individuals experiencing internalized psychodynamic problems leading to psychiatrically defined illness will be considered the target population. If mental health is viewed from a broader perspective, the entire environment in which individuals exist is seen as influencing the client's personal and social functioning. The latter viewpoint is more relevant than the former if a service system is designing programs to meet the needs of Mexican American clients, because ethnic and minority populations generally experience more detrimental social environmental circumstances and stresses than do other cultural groups.

Community mental health centers function with an inherent service philosophy that defines the parameters of center functions. Prior to implementation of the treatment team approach, policy determinations would have to be made at administrative, decision-making levels which recognize that the inclusion of social support services is as vital to the reduction of mental and emotional disturbances as are more established, psychodynamic forms of therapeutic services. The proposed expansion of service parameters is made with the awareness that the reduced staff and financial resources being experienced by the centers have imposed budgetary pressures upon local mental health services. Nonetheless, the proposed treatment team approach calls for a realignment and redefinition of the professional and paraprofessional staff positions that already exist within the center's budget, rather than the creation of additional staff positions.

The implementation of the treatment team service mode would necessitate the development of indigenous paraprofessional recruitment and selection procedures, in-service training modules, and a format for work supervision and evaluation. Recruitment and selection procedures would ideally select individuals representative of the target population who also demonstrate skills of compassion and warmth, a history of active involvement in the community, a comprehensive awareness of community resources and needs, as well as the ability to work within the role limitations defined by the center. The training must be designed in such a way that the indigenous paraprofessional's abilities are enhanced, while basic intervention and assessment skills are developed. Inservice trainings with center clinical professional and indigenous community workers would be necessary to address any disputes regarding the expertise of team members and to resolve any interpersonal issues that might impede the construction and functioning of working coalitions. The inclusion of representatives from the local Mexican American community, as well as Mexican American mental health professionals and consultants, in the program planning and implementation process would facilitate the creation of a culturally appropriate program plan.

Implementation of the treatment team approach presents certain challenges to centers, and it merits consideration for the delivery of more culturally congruent, high caliber mental health services to Mexican Americans. The perceived congruence between the team approach and the needs of Mexican American clients will be summarized.

The proposed practice of a community resident participating in the delivery of services to fellow residents by actively moving within the community, in a very real sense, embodies the spirit of the community mental health movement. If such a practice were to be established utilizing Mexican American indigenous community workers within the barrio, the community mental health center would have made a tangible effort to become visible, accessible and available to barrio residents. If these efforts were complemented by the inclusion of a bilingual/bicultural clinical professional teammate capable of delivering culturally sensitive therapeutic services, the Five A's (Accessibility, Availability, Appropriateness, Acceptability and Accountability), identified by Owan (1980) as requisites in the delivery of services to ethnic minorities, would be vastly improved in contrast to the nature of treatment generally offered to Mexican Americans and other ethnic minorities at present.

Among the characteristics of the team approach that are highly congruent with the nature of the needs and problems experienced by Mexican Americans are:

(1) the cultural proximity of the client and the indigenous community worker in both an environmental and psychological sense;

(2) the reduction of semantic barriers and the provision of at least one team member capable of working in the client's idiom;

(3) the capabilities inherent in the team of dealing with both intrapsychic and extrapsychic sources of stress and disturbance; and

(4) the provision of brief crisis interventions of a tangible nature and/or long-term change-oriented therapy.

Conclusion

The treatment team approach to the delivery of mental health services is offered as an organizational alternative that can be applied within the existing community mental health structure, albeit with some revision. The proposed plan purposefully relates only to staffing and operational issues and avoids the question of the content of culturally relevant mental health services. The Mexican American population is a heterogeneous ethnic group whose comprehensive needs cannot possibly be met by focusing upon one particular treatment modality or therapeutic style. In contrast, because the literature still questions the applicability of therapeutic services to many Mexican Americans, it apears to be of utmost importance to make available to this population any and all types of mental health interventions. The issues of the qualitative effectiveness of mental health treatment for Mexican Americans are of great importance, but the basic issues of availability, accessibility and acceptability still persist unresolved in many communities across Texas. The treatment team approach to the delivery of mental health services emphasizes "opening every door" to treatment with the hope that Mexican American communities will eventually "get their foot in the door" and receive appropriate mental health care. In contrast to the treatment team concept, the impressions and attitudes of Texas CMHC administrators and staff regarding the delivery of treatment services to Mexican Americans are reported in the next chapter.

CHAPTER V

ROLES AND PERCEPTIONS OF TEXAS CMHC STAFF REGARDING SERVICES FOR MEXICAN AMERICANS

The degree of the Texas mental health system's responsiveness to the needs of Mexican Americans and other special populations is in large part determined by the composition of its staff and their attitudes regarding the delivery of accessible and acceptable services to Mexican Americans. If CMHC staff attitudes regarding the delivery of culturally relevant, linguistically appropriate services are not compatible with the "spirit of the law" elaborated in PL 94-63 and its ensuing amendments and regulations, it is likely that the services will fail to fulfill the intent of the community mental health concept outlined in the legislation.

Texas CMHC staff compositions and the perceptions of selected CMHC staff members regarding the delivery of community mental health services to Mexican Americans are presented as indicators of the "climate" in which mental health services are being offered. The data reviewed in this chapter are compiled from CMHC EEO staffing reports to the Texas Department of Mental Health and Mental Retardation, structured interviews conducted by the Mental Health Research Project with selected Texas CMHC personnel, and the Evaluation of the Texas/New Mexico Symposium on the Delivery of Mental Health Services to Mexican Americans (Andrade, 1978). Much of the data presented is of a subjective nature, which makes it difficult to assess empirically. Despite the limited generalizability and empirical strength of the data, it represents a preliminary effort to study the mental health system and its services as they are operationalized by the CMHC administrators and treatment providers.

CMHC Staffing Patterns in Relation to Treatment Services for Mexican Americans

Because the treatment intervention is an interactional phenomenon, both its process and content are largely determined by the personalities, roles and cultural backgrounds of both the service deliverer and service recipient. The therapeutic bond that develops between the service deliverer and service recipient is not insured by cultural similarity between the two parties, but it is surely enhanced by the service deliverer's knowledge of, respect for, and ability to work within the client's cultural milieu. The high level of cultural awareness that is believed by most Mexican American mental health professionals and scholars to be necessary for effective service delivery to Mexican Americans will logically be more prevalent in mental health settings where Mexican Americans have input into mental health program design and service delivery. An analysis of the staff composition at Texas CMHCs, however, reveals a deficiency of equal representation by Mexican Americans at all staff levels engaged in the design or implementation of treatment programs.

EEO staffing data reported by 28 CMHCs in Texas to the Texas Department of Mental Health and Mental Retardation previously compiled by Fiedler (1979) are presented in Table 1. Categories 1, 2, 3, 5 and 6 will be more closely examined as those CMHC staff levels can be directly involved in the entire treatment process ranging from initial contact with the client to administration of the service delivery programs.

TABLE 1

COMBINED CURRENT WORKFORCE FOR ALL COMMUNITY MHMR CENTERS (AS OF 9/1/78)

	EEO-1 OFF./ADM.	EEO-2 PROF.	EEO-3 TECH.	EEO 4 P.S.W.	EEO-5 PARA P.	EEO-6 OFF./Cler.	EEO-7 S.C.W.	EEO-8 S./M.W.	* TOTALS
White	158 ** (83)	1137 (74)	135 (52)	14 (61)	287 (47)	479 (61)	6 (74)	36 (27)	2435 (63)
Black	12 (6)	201 (13)	62 (24)	7 (30)	185 (31)	114 (14)	1 (13)	59 (44)	689 (17)
Hispanic	14 (7)	189 (12)	61 (24)	2 (9)	129 (21)	186 (24)	1 (13)	38 (29)	733 (19)
Asian	5 (3)	10 (1)	1 (-)		1 (-)	1 (-)			20 (1)
Indian	2 (1)	2 (-)			4 (1)	5 (1)			13 (-)
Totals	191	1539	259	23	606	785	8	133	3890

* The total includes 346 staff from two centers which did not report ethnic breakdown by EEO category

* * Numbers in parenthesis are percents of column totals

BEST COPY AVAILABLE

Within the centers reporting data by ethnic groups, 83% of EEO Category 1, including officials and administrators, are White while Hispanics constitute only 7% of that staff category. An equally disproportionate representation is observed in the data regarding professionals in Category 2. Whereas 74% of the reported professional workforce are White, only 12% are Hispanic. Of the 189 Hispanic professionals reported in Table 1, an analysis of individual CMHC EEO Data reported by Fiedler (1979) reveals that 132 Hispanic professionals (70% of the total group) are employed at five CMHCs located in metropolitan areas around the state. The remaining 30% of the Hispanic professionals reported are accounted for in the data from 23 other CMHCs. The aggregation of data across the state, therefore, masks the fact that the majority of the CMHCs in Texas are seriously underrepresented with regard to Hispanic professionals.

The EEO figures in Table 1 indicate that Hispanics are proportionately represented in categories 3 (technicians), 5 (paraprofessionals), and 6 (office/clerical) in relation to their population status within Texas. The proportionate Hispanic representation in categories 3, 5 and 6, in comparison with the inequitable representation in categories 1 and 2, creates a service delivery system that is "bottom-heavy" with Hispanic input. Consequently, Hispanic staff may have little or no impact upon the design of culturally appropriate treatment services for Mexican American clients. It is also likely that the lower level Hispanic staff play no viable role in increasing the center's awareness of Mexican American cultural dynamics and the components of bilingual/bicultural services. Rather than serving in the consultative capacity described within PL 94-63, Sec. 206(c)(7)(d), it appears unlikely that the majority of the Hispanic staff within the CMHC system are instructive, influential elements. More probably their function is one of facilitating the CMHCs' interaction with Mexican American clients in the role of receptionists and interpreters.

CMHC Treatment Staff Perceptions Related to Mexican Americans

In order to become familiar with the treatment attitudes and procedures found among CMHC staff, the Mental Health Research Project conducted ten site visits to CMHCs in Texas during 1980, at which time structured interviews were conducted with medical directors, clinical directors and bilingual/bicultural service deliverers employed at these centers. The locations of the ten site visits were chosen for their representativeness in terms of location within the state, the distribution of Mexican American population within the state, and the centers' willingness to cooperate with the research efforts. Although the information obtained from such a small sample may be limited in terms of its representativeness for each CMHC individually, it nonetheless has enabled the formulation of several preliminary generalizations that reflect the operations, functions, and attitudes of several CMHCs and their staffs throughout Texas. The data, therefore, is most meaningful as descriptors of tendencies that are likely to recur throughout other CMHCs in the state.

The purpose of the interviews with the three types of clinical staff was to elicit each respondent's impressions regarding the services delivered by the CMHC, the respondent's functions within the center, the perceived responsiveness of the Mexican American community and community-at-large to the services, the center's staffing patterns, and the inclusion of bilingual/bicultural treatment modalities. Although the open-ended nature of the instrument and the small sample limit statistical analysis of the results, the interviews did enable the Mental Health Research Project to identify tendencies among the three positions interviewed with respect to treatment. A summary of those tendencies characterizing each staff position follows.

Medical Directors

Of the nine medical directors who were interviewed, all were psychiatrists or had had experience as physicians in psychiatric settings. The majority of the medical directors were males (8 of 9) and Anglo (7 of 9). One Mexican American and one Asian American were within the group of respondents.

The tenure of the physicians at their respective CMHCs appears to be a significant variable influencing the individual's perceptions of the center and its responsiveness to the Mexican American community. Four medical directors have been actively involved in their community's implementation of the community mental health center and in some cases have been the only medical director. The remaining five respondents have all been at their respective CMHCs for less than five years. The physicians with longer tenure, who in many cases helped develop the extant service delivery systems, regard their respective CMHCs as providing adequate services to the entire community. Those assessments appear to be subjective judgments based upon the respondents' involvement with the CMHC, as these physicians are either unaware of any evaluative measures of service effectiveness at the center or refer to evaluative measures that have not yet been fully operationalized. The responses of the five physicians with shorter tenure indicate less certainty regarding the effectiveness of their center within the community. One of the physicians within the latter group stated that the center is definitely not meeting the needs of the Mexican American community. The other four indicate that their unfamiliarity with the Mexican American community limited them from determining whether the CMHC is adequately serving the minority population.

The level of community input received by the medical directors appears to be limited to their client contacts, which constitute a limited segment of the local population. Eight of the nine physicians said they do not meet with community advisory groups, generally attributing this failure to their excessive workload. Although the majority of the respondents identify citizen advisory groups and the CMHC Board of Trustees as means to obtain input from the community-at-large, six of the nine physicians are uncertain about how input from the Mexican American community is obtained.

Regarding the delivery of treatment services, the responses of seven of the nine physicians indicate little or no awareness of the influence of cultural variables upon mental health treatment. Rather, the responses range from a denial of ethnic differences to the belief that acknowledging cultural factors in treatment is detrimental to the delivery of equitable services to all. Six of the nine medical directors are totally reliant upon translators to work with monolingual, Spanish-speaking clients. One respondent speaks fluent Spanish and two indicated that they speak limited Spanish.

The majority of the medical directors (7 out of 9) indicate that Mexican Americans do not require types of treatment that their CMHCs could not provide. The same number of respondents also state that Mexican Americans are as cooperative in fulfilling prescribed treatment plans as any other client. These responses indicate that Mexican Americans are perceived by the physicians to be suitable to receive the psychiatric services available and that Mexican Americans are not generally resistant to treatment, both of which dispute the findings of several previous research efforts.

Clinical Directors

Eleven clinical directors representing nine CMHCs were interviewed. Eight of the respondents were Anglo, two were Mexican American, and one was a Spaniard, while two were female and nine male. The clinical directors have been academically trained as either social workers (5 of 11) or psychologists (6 of 11).

The roles and functions of the clinical directors vary widely among CMHCs. Seven respondents have primarily administrative roles and appear to be actively involved with the management and policy development at the center. These individuals are involved in the development and implementation of treatment services, although their interviews indicate little or no direct service contact with clients. These seven respondents, however, are engaged in establishing collateral service agreements with other human service agencies, communicating the center's purpose to the community, and at times informally engaging in the development of alternative funding sources. The four remaining respondents appear to fill a mid-management role involving direct client services, as well as clinical supervision and management responsibilities. Three of the nine respondents indicate that they are interim appointments and, as such, they have limited input into the center's system.

The clinical directors indicate that the availability of CMHC services delivered in Spanish varies among the nine CMHCs. While four centers are reportedly able to offer the full range of services in Spanish, an equal number of centers have only partial coverage with regard to Spanish-speaking staff. One center's range of bilingual services are not known by its two clinical directors. When asked about the center's efforts to serve Mexican Americans through acceptable and relevant psychotherapy, the clinic directors report that seven centers are able to offer psychotherapy in Spanish. In some CMHCs, however, that means that one Spanish-speaking staff member, who is not necessarily academically trained to offer diagnostic and treatment services, is available to interact verbally with Spanish-speaking clients. Two centers report that no specific in-house measures have been taken to offer acceptable and relevant psychotherapy to Mexican Americans. According to their clinical directors, only two of the nine centers have attempted to observe the customs and rituals of Mexican American culture through milieu therapy.

The majority of the clinical directors (7 of 11) indicate that Mexican American clients generally do not come to the CMHC with inappropriate or uninformed needs. The impressions of the respondents regarding the utilization of available services by Mexican American clients indicate that seven of the eleven clinical directors believe that the CMHC services are well-utilized by Mexican Americans. Three of the remaining respondents believe that the utilization by Mexican Americans is low, and one clinical director is uncertain. As noted by one respondent, the utilization figures produced at that individual's center indicate that Mexican Americans are utilizing services in proportion to their representation in the community. Many of the services accounted for, however, are medication services. The underrepresentation of Mexican Americans in psychotherapeutic services, therefore, is generally overlooked if only utilization figures accumulated by the CMHCs are examined.

When asked to identify factors that limit Mexican American utilization of the centers, the clinical directors most frequently offer the stigma associated with seeking mental health care (7 of 11 respondents) and lack of knowledge about the CMHC on the part of the Mexican American community (6 of 11 respondents).

The lack of interface between the CMHC and Mexican Americans is seen in terms of the latter's reluctance to access the system due to a lack of trust in it, which is linked to the existence of cultural barriers (such as differences in language or sex roles) on both sides. Three respondents state that the strong family support system characteristic of the Mexican American culture reduces the need to seek outside support services. Only three of the eleven clinical directors indicate that an inadequate number of bilingual/bicultural staff limit Mexican American utilization of services. The same number believe that inaccessibility of the CMHC to the Mexican American population influences service utilization.

The clinical directors identify six alternative support systems that they believe are utilized by Mexican Americans seeking mental health services who do not come to the CMHC. Listed in order of the frequency with which they were mentioned, the alternatives include: 1) the clergy, 2) the family, 3) curanderos, 4) health care providers, 5) social service providers, and 6) the schools.

Seven clinical directors indicate that they attend regular citizen advisory board meetings. Only three respondents, however, identify the citizen advisory board as a means of obtaining input from the community regarding services. Other social service agencies are seen by ten of the eleven respondents as a means for the community to inform the center of its needs. The CMHC Board of Trustees, community leaders, the schools, the clergy and the media are also mentioned as links between the various communities and the CMHCs.

Bilingual/Bicultural Service Deliverers

In order to obtain input from a CMHC staff member who is likely to be involved in mental health treatment services with Mexican Americans, a structured interview was conducted with ten individuals identified by their respective CMHCs as being bilingual/bicultural service providers. Because the number of such individuals is so limited at certain CMHCs, this group of respondents has widely differing levels of academic training that range from psychiatry to paraprofessional levels. Specifically, the group of respondents include one psychiatrist, four master's level employees, three bachelor's level staff, and two paraprofessionals who indicated that they have not yet completed baccalaureate studies.

Nine of the ten respondents in this group were Mexican American. The final bilingual service respondent was of Peruvian origin; no Mexican Americans were on the staff of that individual's CMHC at the time of the research team's site visit. Sixty percent of the group are female.

Three of the ten respondents perceive their CMHC to be making a sincere and adequate effort to serve the community-at-large and the Mexican American community specifically. Three service deliverers believe that the CMHC does perform adequate services for the community-at-large but is inadequately serving the local Mexican Americans due to insufficient numbers of bilingual/bicultural Mexican American staff, as well as limited public relations and outreach efforts in the barrio. Two respondents believe that their centers are not making a concerted effort to meet the needs of the Mexican American community, although the CMHCs are having a positive impact upon the entire community. The final two service deliverers respond that the services offered at their centers are not fully addressing the needs of either the entire community or Mexican American residents.

All the respondents agree in their perception that Mexican Americans feel welcome at the center, but there is some acknowledgment that this does not indicate how the local CMHCs are perceived by the Mexican Americans who do not come for services. Only one of the ten service deliverers maintains that the local CMHC is utilized fully by Mexican Americans. The others indicate that Mexican Americans who could benefit from the center's services have not been served by the existing system. As one service deliverer notes, the CMHC in his community appears to have engaged a significant number of Mexican Americans in alcohol and drug abuse services, but little impact is being achieved with regard to other mental health problems.

Similar alternative support systems are identified by the bilingual/bicultural interviewees as are noted by the clinical directors. Listed in order of frequency, the front-line care providers indicate that Mexican Americans seeking mental health care who do not come to the CMHCs utilize: 1) curanderos, 2) the extended family, 3) the clergy, 4) health care providers, and 5) other social service agencies. Thirty percent of the respondents add that despite the alternatives, a significant number of Mexican Americans do not have their mental health needs met. As one respondent stated, "They (Mexican Americans) are staying at home, in jail, or in the hospital until the evaluation cycle begins again" (Mental Health Research Project Field Notes, 1980).

Assessing the responsiveness of Mexican American clients to CMHC services, 80% of the respondents believe their centers' therapy and services to be acceptable to Mexican Americans. Within this group of respondents, however, it is noted that the services must be delivered in a bilingual/bicultural fashion and preferably by a Mexican American care provider if the treatment process is to be maximally acceptable to Mexican American clients. The respondents from two CMHCs are unable to assess meaningfully the responsiveness of such clients. One care provider notes that no trained Spanish-speaking therapists are on staff at that individual's CMHC. The other states that 90% of the Mexican Americans being served at the center receive only medication so that it is difficult to assess how these clients might respond to a broader range of therapeutic services.

One of the ten bilingual/bicultural workers assesses traditional therapeutic goals as being consistent with the Mexican American culture. The remaining nine respondents are in agreement that considerable cultural revision is frequently necessary in order to adapt cognitive, confrontive and intellectualized therapies to accommodate the cultural values held by many Mexican American clients. The opinion of the service providers is equally divided regarding the sensitivity of non-Mexican American staff and Mexican American staff to Mexican American culture and customs. Fifty percent find their fellow Anglo employees to be generally sensitive, while the other half of the workers believe that cultural ignorance, misunderstanding and discriminatory attitudes can be found among non-Mexican American staff.

The bilingual/bicultural service providers make numerous recommendations regarding improving the capacity of the CMHCs to serve Mexican American clients. Listed in order of frequency, the recommendations include: 1) more Mexican American professionals at all CMHC staff levels, 2) more community outreach into the barrio, 3) increased publicity and information dissemination to the Mexican American population, 4) the employment of more Mexican American therapists, 5) the training and sensitization of the entire staff to Mexican American culture, and 6) an increase in the number of bilingual information signs, receptionists and telephone operators.

CMHC Staff Perceptions Measured at the Texas/New Mexico Symposium

The Texas/New Mexico Symposium on the Delivery of Mental Health Services to Mexican Americans held in 1977 brought together administrators, service staff and board members from Texas and New Mexico to confer on the development of improved community mental health services to Mexican Americans. Primarily a working conference, the participants discussed the issues related to the bilingual/bicultural delivery of services as well as generated recommendations. The four categories of CMHC staff and representatives in attendance at the conference included executive directors, program directors, other key Mexican American staff members, and CMHC board of trustees members. The symposium evaluation document includes attitude measures of the conference participants regarding cultural treatment issues and services delivery to Mexican Americans.

The symposium evaluation process consisted of pre-and post-conference questionnaires as well as workshop assessments completed by the participants. The conferees ranked fifteen factors according to their perceived importance to the delivery of quality mental health services to Mexican American consumers. In order of priority, the fifteen factors listed in the evaluation document are:

1) bilingual/bicultural CMHC staff,
2) location of the CMHC close to the barrio and to central transportation networks,
3) greater emphasis on the provision of individualized counseling and psychotherapy in Spanish,
4) representation of bilingual/bicultural consumers on CMHC Board of Trustees,
5) inservice training for monolingual/monocultural staff of CMHCs regarding Mexican American culture,
6) involvement of Mexican American folk healers in the CMHC treatment system,
7) use of bilingual signs and printed material in CMHCs,
8) use of bilingual/bicultural paraprofessional staff in CMHCs,
9) formation of consumer advocacy groups to promote Mexican American mental health services,
10) bilingual public relations/educational campaigns directed at the Spanish-speaking community,
11) utilization of more group therapeutic approaches,

12) development of bilingual/bicultural doctoral training programs for mental health service providers and researchers in the state university system,

13) organization of more CMHCs in the state,

14) utilization of bilingual/bicultural service delivery, and

15) increased emphasis on affirmative action programs to recruit bilingual/bicultural staff for CMHC positions (Andrade, 1978, pp. 10-11).

The responses of the conference participants reveal distinctions in the attitudes of different CMHC staff levels as well as ethnic variations. The executive directors of CMHCs (of which only 9 of the 23 invited attended the symposium) are consistent in ranking the service delivery factors lower than most of the other respondents. Of all the groups in attendance, the executive directors give twelve of the fifteen factors the lowest ranking. They differ significantly in their attitudes regarding the provision of psychotherapy in Spanish, the representation of bilingual/bicultural providers on boards, the formation of advocacy groups for Mexican American health services, the utilization of bilingual/bicultural service models, an increased emphasis on affirmative action to promote the employment of more bilingual/bicultural staff, and the development of more bilingual/bicultural doctoral programs.

With regard to ethnic variation, the Mexican American conferees rank 14 of the 15 treatment factors as being of greater importance than do the Anglo American participants. The only factor ranked higher by Anglo Americans is the one related to bilingual/bicultural training of monolingual/monocultural CMHC staff. On 11 of the remaining 14 treatment factors, the attitudes of the Mexican American and Anglo American participants differ significantly with the Mexican Americans consistently ranking the treatment factors as more important than do their Anglo American counterparts.

Conclusion

Although the need for culturally relevant treatment services is clearly defined in federal legislation and subsequent policy guidelines, CMHC staffing data, interviews with Texas CMHC treatment staff, and the Texas/New Mexico Symposium evaluation of CMHC staff attitudes toward cultural treatment factors all indicate considerable variance with regard to center input from Mexican American staff and to an awareness of cultural issues in the treatment of Mexican Americans. The relative underrepresentation of Mexican American input at administrative and professional levels and the apparently limited awareness of CMHC administrators to cultural treatment factors that affect services delivery to Mexican Americans reduces the likelihood that the Texas mental health system will, of its own initiative, be able to develop a system more responsive to the needs of Mexican Americans and other linguistic minorities.

The apparent lack of impetus to revise the existing mental health services network in no way diminishes the responsibilities of the Texas mental health system to address the needs of the state's Mexican American population. As the knowledge base regarding the delivery of bilingual/bicultural mental health services is rapidly being developed by minority practitioners, researchers and scholars, the question "How does a CMHC provide culturally relevant services to Mexican Americans?" is no longer a major obstacle. Rather, the question that many community mental health providers or supporters continue to ask is, "Why should a CMHC provide culturally relevant, special services to Mexican Americans?" The final chapter discusses the implications of implementing such services at CMHCs in Texas.

CHAPTER VI

THE IMPLICATIONS OF IMPLEMENTING BILINGUAL/BICULTURAL TREATMENT SERVICES AT CMHCS IN TEXAS

This monograph endeavors to familiarize the reader with several key issues regarding the delivery of culturally relevant services to Mexican Americans. Among those discussed are: 1) the federal legislation and policy calling for such services, 2) cultural considerations affecting the basic intervention process, and 3) previously implemented or proposed alternative designs for the delivery of bilingual/bicultural mental health services to Mexican Americans. Considerable discrepancy appears to exist between the manner in which Mexican Americans are currently served by Texas CMHCs and the ideal bilingual/bicultural treatment approach called for in the literature reviewed within this monograph. If culturally relevant, linguistically appropriate mental health services are to be offered to Mexican Americans, many aspects of the existing CMHC service system (such as ethnic staffing patterns, location of services, treatment modalities utilized, administrative attitudes, outreach and publicity efforts, and program planning) must necessarily be reevaluated in order to determine their effectiveness or utility in accomplishing that task. If CMHCs are to undertake such self-scrutiny and make a commitment to becoming more effective for Mexican Americans, the need for culturally relevant services and the implications of offering such services for the CMHCs must be elaborated.

Why are Culturally Relevant Services for Mexican Americans Justified?

Despite the growing volume of literature on the importance of cultural considerations in the delivery of mental health services, many care-providers fail to acknowledge the need for culturally specific services. These individuals often believe that one service delivery system can be equally applicable to the needs of all ethnic groups and that individual resistance to treatment is the reason why certain groups underutilize or benefit less from available services. This viewpoint, however, ignores the fact that an individual's psychological and emotional state of being is the result of an interchange between the person's intrapsychic nature and the sociocultural environment in which he or she exists. Failure to recognize cultural considerations in the delivery of mental health care severely restricts the potential effectiveness of such services. As noted by the Hispanic scholars who reported to the President's Commission on Mental Health:

> The healing intervention must aim at repairing individuals' linkages with their sociocultural support system while helping to reduce the intensity of their internal conflicts. These two processes go hand in hand. A mental health program which attempts to reduce patients' anxieties with medication or individual therapy while neglecting or assaulting their sociocultural values will defeat its own purpose and cause more damage than benefit. In short, individuals have their roots in their ethnicity. Damage to these ethnic roots can cause serious psychological trauma, while respect for them facilitates the development of a therapeutic alliance and healing process. (Report of the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans, 1978, p. 910)

Culturally relevant mental health services for Mexican Americans are needed because those services that are currently available at CMHCs are generally rooted within the Anglo American cultural system by virtue of the fact that they are primarily designed and delivered by Anglo Americans. Because the current CMHC service delivery system lacks adequate Mexican American input at the policy-making, administrative and professional levels, it is unlikely that the service outcome will be maximally meaningful to Mexican Americans. Because the existing system addresses mental health needs from an Anglo American perspective, it is reasonable for Mexican Americans to call for bilingual/bicultural mental health services from the CMHCs which are mandated to meet the specific needs of all numerically significant minority groups within their service areas.

Often the proponents of culturally specific mental health services encounter opposition from mental health program administrators and staff who contend that such programs are discriminatory. Because culturally specific programs are not equally applicable to all cultural and ethnic groups, opponents of such mental health service concepts refuse to consider the implementation of alternative service designs and continue the provision of Anglo-oriented mental health services that are, for the most part, planned and delivered by Anglo staff. The outcome is still a mental health services program that is culturally irrelevant to Mexican Americans and other ethnic minority groups. The argument that culturally specific services for Mexican Americans and other ethnic minority groups should not be implemented because they are discriminatory is unjustified because it fails to recognize that the current mental health system is generally discriminatory with regard to the needs of many Mexican Americans.

The projected increase in the number of Mexican Americans in Texas also legitimizes the need for bilingual/bicultural mental health services. In addition to being the most rapidly growing minority group within the nation, 53 percent of the current Mexican American population is composed of individuals 21 years of age and younger while 37 percent of the Anglo American population and 47 percent of the Black American population fall within the same age group (Ramirez, in press). The heaviest utilization of CMHC mental health services is found to occur among individuals who are 21 - 64 years of age (Ramirez, in press). A larger number of Mexican Americans, therefore, will be entering the age groups in which the greatest utilization of CMHC services occurs.

Implications of Delivering Bilingual/Bicultural Services for CMHCs

Once hailed as new innovations in mental health care, CMHCs are now being closely scrutinized and/or criticized by mental health care providers, local, state and federal governmental funding bodies, and public interest groups representing certain sectors within communities. The critics contend that the CMHCs have failed to establish that they are the most adequate mechanism for the delivery of mental health services. The increasing recognition of public mental health problems and the decreasing availability of adequate fiscal resources within the tight economy of the 1980's, however, make it imperative that funds be allocated and services delivered in the most effective and efficient manner possible.

The widespread concern about the effectiveness of CMHCs is due in part to their failure to be sufficiently accountable. As Chu and Trotter (1974) report, the Nader Report on the National Institute of Mental Health (NIMH) criticizes the CMHCs for having been accountable neither backward to the NIMH nor forward to the community residents who are to be served. The concern about the CMHCs' accountability is spreading and potentially threatens future funding and the existence of community mental health centers.

Although the difficulties inherent in evaluating the effectiveness of mental health services are considerable, the continued operation of CMHCs requires that funding bodies and the community recognize the utility of CMHCs. As Musto states:

> The pressure to justify the expense and show the effectiveness of various mental health treatments is increasing, and in this new climate CMHC advocates are finding it hard to justify their continued funding as separate organizations. Even those convinced that mental health treatment is of

> value have suggested that the CMHCs be integrated with social service agencies or with broader health care systems (such as general hospitals or health maintenance organizations), instead of continuing to ask for what their critics call special privileges through categorical grants. (Musto, 1975, p. 77)

The continued operation of the CMHCs appears to be at least partially dependent upon their establishing themselves as deliverers of effective treatment services and the organization of a local community constituency that is willing to attest to the center's usefulness and effectiveness in the area. In order to do so, CMHCs may have to consider the implementation of innovative treatment approaches which have been developed in order to maximize treatment effectiveness with a minority client population rather than adhering to traditional psychotherapeutic methods that have been criticized as being suitable primarily for individuals comfortable with verbal, introspective treatment approaches.

The addition of bilingual/bicultural services to the regimen of treatment services available at CMHCs would both testify to a sincere commitment on the centers' part to meet the mental health needs of the Mexican American community and make available services that are reported to increase Mexican American utilization of and responsiveness to mental health care. In turn, a responsiveness on the part of CMHCs to the treatment needs of Mexican Americans would most likely generate a supportive attitude on the part of Mexican Americans toward the CMHCs. The Mexican American community, which is growing in numbers and political forcefulness, could then function as an advocate for the continued operation of the CMHCs.

The Report to the President's Commission on Mental Health by the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans illustrates the Hispanic community's interest in the continuation of the CMHC service delivery system. The majority of the Hispanic population lives in poverty and cannot afford to pay for mental health care. Hispanics, therefore, have a sincere interest in the continued provision of community mental health services assuming, of course, that those services endeavor to reach Hispanics. The Report notes that the phase-out of federal support for CMHCs without compensation by proportionate increases in state contributions and the amendements to PL 94-63 that increased the number of mandated services without increasing funding have imposed difficulties for the CMHCs in attempting to deliver mental health services. With regard to CMHCs, the Panel recommends that:

> (a) Adequate and stable funding be provided to continue the operation of CMHCs. Implicit in this recommendation is the need to stipulate a firm and stable shared commitment on the part of federal and state governments to the continued funding of mental health services; (b) guidelines for implementation of PL 94-63 allow for greater flexibility in the provision of mandated services; and (c) the specific needs of the Hispanic community be explicitly recognized and addressed in the drafting of any state or federal legislation regarding accreditation. (Report of the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans, 1978, p. 918)

The recommendations indicate that Hispanics have assumed the role of an ally rather than an adversary with regard to the continuation of CMHCs. The recommendations do, however, insist that the mental health system be responsive in the following manner:

> If we accept the concept of biculturality and the right to treatment within one's cultural framework, it follows that Hispanics must participate in every aspect of the delivery of services to members of their ethnic group, and that the members of the dominant culture must become acquainted with and sensitive to the cultures of the various

> ethnic groups represented among their clients and patients. (Report of the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans, 1978, p. 911)

The response to the Mexican American community in Texas must now come from the CMHCs. The literature reviewed within this monograph clearly indicates that Mexican Americans do engage meaningfully in a wide variety of mental health treatment services if the services are offered in a culturally sensitive, linguistically appropriate manner.

As has been noted, existing mental health service networks can be adapted to offer bilingual/bicultural services, but not without considerable revision on the centers' part. Reassessment of the CMHCs' basic philosophical outlook and behavioral responses to Mexican American clients are necessary in order to determine whether the Mexican American culture is respected and affirmed throughout the treatment process. An aggressive recruitment campaign of Mexican American administrators and professionals by CMHCs is also necessary if the service system is to reflect Mexican American input throughout. Finally, the Mexican American community must be informed via media campaigns and outreach efforts that the CMHCs exist to serve their mental health needs, as well as those of other Texas residents. Through such efforts, the CMHCs would move much closer to realizing their stated intent of meeting the mental health needs of Mexican Americans in Texas. A mutually beneficial alliance could then evolve between the CMHCs, which exist in order to fulfill the public's mental health needs, and the Mexican American community, which could offer needed support and substantiation of the CMHCs' services efforts and potential effectiveness in Texas.

REFERENCES

Abad, V., Ramos, J., & Boyce, E. A model for delivery of mental health services to Spanish-speaking minorities. *American Journal of Orthopsychiatry*, 1974, *44*, 584-596.

Achor, S. *Mexican Americans in a Dallas barrio*. Tucson: University of Arizona Press, 1978.

Acosta, F. X. Mexican American and Anglo American reactions to ethnically similar and dissimilar psychotherapists. In R. Alvarez (Ed.), *Delivery of services for Latino community mental health*. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #2, 1975.

Acosta, F. X. Ethnic variables in psychotherapy: The Mexican American. In J. L. Martinez (Ed.), *Chicano psychology*. New York: Academic Press, 1977.

Acosta, F. X., & Sheehan, J. G. Psychotherapist ethnicity and expertise as determinants of self-disclosure. In M. R. Miranda (Ed.), *Psychotherapy with the Spanish-Speaking: Issues in research and service delivery*. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #3, 1976.

Albronda, H. F., Dean, R. L., & Starkweather, J. A. Social class and psychotherapy. *Archives of General Psychiatry*, 1964, *10*, 276-283.

Anastasi, A. *Psychological testing* (4th ed.). New York: Macmillan, 1976.

Andrade, S. J. Results and analysis of pre- and post-questionnaires completed by participants. In S.J. Andrade (Ed.), *Evaluation of the Texas/New Mexico symposium on the delivery of mental health services to Mexican Americans* (Vol. II of the Proceedings). Houston, Tx.: Chicano Training Center, 1978.

Andrade, S., & Burstein, A. Social congruence and empathy in paraprofessional and professional mental health workers. *Community Mental Health Journal*, 1973, *9*, 388-397.

Bachrach, L. L. Utilization of state and county mental hospitals by Spanish-Americans in 1972. (NIMH Division of Biometry, Statistical Note 116, DHEW Publication No. (ADM) 75-158). Washington, D.C.: U.S. Government Printing Office, 1975.

Bloom, B. L. *Community mental health: A historical and critical analysis*. Morristown, N.J.: General Learning Press, 1973.

Bloombaum, M., Yamamoto, J., & James, Q. Cultural stereotyping among psychotherapists. *Journal of Counseling and Clinical Psychology*, 1968, *32*, 99.

Boulette, T. R. Assertive training with low-income Mexican American women. In M. R. Miranda (Ed.), *Psychotherapy with the Spanish-speaking: Issues in research and service delivery*. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #3, 1976a.

Boulette, T. R. *Determining needs and appropriate counseling approaches for Mexican American women: A comparison of therapeutic listening and behavioral rehearsal*. San Francisco: R and E Research Association, 1976b.

Brusco, B. A. *Boards and councils of the Texas Department of Mental Health and Mental Retardation*. San Antonio, Tx.: Intercultural Development Research Association, 1979.

Buchanan, B. & Choca, P. R. Mutuality of expectations and cultural etiquette: Some considerations and a proposal. In P. P. Martin (Ed.), *La Frontera perspective: Providing mental health services to Mexican Americans*. Tucson: La Frontera Center, Inc., Monograph #1, 1979.

Burruel-Farnam, G. The definitional process among Mexican Americans and its effects on the utilization of mental health services. In P. P. Martin (Ed.), *La Frontera perspective: Providing mental health services to Mexican Americans*. Tucson: La Frontera Center, Inc., Monograph #1, 1979.

Burruel, G. & Chavez, N. Mental health outpatient centers: Relevant or irrelevant to Mexican Americans. In A. B. Tulipan, C. L. Attneave, & E. Kingstone (Eds.), *Beyond clinic walls*. University, Al.: University of Alabama Press, POCA Perspectives 5, 1974.

Carrillo, C. Directions for a Chicano psychotherapy. In J. M. Casas & S. E. Keefe (Eds.), *Family and mental health in the Mexican American community*. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #7, 1978.

Casas, J. M. Applicability of a behavioral model in serving the mental health needs of the Mexican American. In M. R. Miranda (Ed.), *Psychotherapy with the Spanish-Speaking: Issues in research and service delivery*. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph 3, 1976.

Chavez, N. Issues of non-responsiveness vs. responsive mental health services for Mexican Americans: Implications for practice. In F. Souflee & G. Valdez (Eds.), *Proceedings of the Texas/New Mexico Symposium on the Delivery of Mental Health Services to Mexican Americans* (Vol. I). Houston, Tx.: Chicano Training Center, 1978.

Chavez, N. Mexican Americans' expectation of treatment, role of self and of therapists: Effects on utilization of mental health services. In P. P. Martin (Ed.), *La Frontera perspective: Providing mental health services to Mexican Americans*. Tucson: La Frontera Center, Inc., Monograph #1, 1979.

Chu, F. D. & Trotter, S. *The madness establishment* (Nader Report on the National Institute of Mental Health). New York: Grossman Publishers, 1974.

Cobbs, C. W. Community mental health services and the lower socioeconomic class: A summary of research literature on outpatient treatment (1963-1969). *American Journal of Orthopsychiatry*, 1972, *42*, 404-414.

Cuellar, I. The utilization of mental health facilities by Mexican Americans: A test of the underutilization hypothesis. Unpublished doctoral dissertation. The University of Texas at Austin, 1977.

Duran, R. (Ed.) *Salubridad Chicana: Su preservacion y mantenimiento - The Chicano plan for mental health*. Denver, Colorado, 1975.

Edgerton, R. B. & Karno, M. Mexican American bilingualism and the perception of mental illness. *Archives of General Psychiatry*, 1971, *24*, 286-290.

Edgerton, R. B., Karno, M., & Fernandez, I. Curanderismo in the metropolis: The diminished role of folk psychiatry among Los Angeles Mexican Americans. *American Journal of Psychotherapy*, 1970, *24*, 124-134.

Fiedler, F. P. *Utilization, staffing and community profiles: Community mental health mental retardation centers in Texas*. San Antonio, Tx.: Intercultural Development Research Association, 1979.

Flores, J. L. The utilization of a community mental health service by Mexican Americans. *International Journal of Social Psychiatry*, 1978, *24*, 271-275.

Gibson, G. Training aspects in working with Chicanos. Paper presented at the American Group Psychotherapy Association Meeting, 1975.

Giordano, J. & Giordano, G. P. Ethnicity and community mental health. Community Mental Health Review, 1976, 1, 1-26.

Gomez, E. & Cook, K. Chicano culture and mental health: Trees in search of a forest. In Chicano culture and mental health. San Antonio: Centro del Barrio, Our Lady of the Lake University, 1978.

Gregory, D. D. Transcultural medicine: Treating Hispanic patients. Behavioral Medicine, 1978, 22-29.

Hall, J. Historical development of the Community Mental Health Centers Act, 1963-1979. Paper presented to the Texas State Mental Health Advisory Council, Austin, Texas, March 9, 1979.

Hallowitz, E. The role of a neighborhood service center in community mental health. American Journal of Orthopsychiatry, 1968, 38, 705-714.

Heiman, E. M., Burruel, G., & Chavez, N. Factors determining effective psychiatric outpatient treatment for Mexican Americans. Hospital and Community Psychiatry, 1975, 26, 515-517.

Heine, R. W. & Trosman, J. Initial expectations of the doctor-patient interaction as a factor in continuance in psychotherapy, Psychiatry, 1960, 23, 275-278.

Herbert, G., Chevalier, M., & Meyers, C. Factors contributing to the successful use of indigenous mental health workers. Hospital & Community Psychiatry, 1974, 25, 308-310.

Herrera, A. E., & Sanchez, V. C. Behaviorally oriented group therapy: A successful application in the treatment of low-income Spanish-speaking clients. In M. R. Miranda (Ed.), Psychotherapy with the Spanish-speaking: Issues in research and service delivery. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #3, 1976.

Hogan & Hartson correspondence to the Honorable Joseph A. Califano, Secretary, Department of Health, Education, and Welfare, Washington, D.C., November 21, 1978.

Jaco, E. G. Mental health of the Spanish Americans in Texas. In M. F. Opler (Ed.), Culture and mental health: Cross-cultural studies. New York: Macmillan Co., 1959.

Kahn, M. W. & Heiman, E. Factors associated with length of treatment in a barrio-neighborhood mental health service. International Journal of Social Psychiatry, 1978, 24, 259-62.

Karno, M. The enigma of ethnicity in a psychiatric clinic. *Archives of General Psychiatry*, 1966, *14*, 516-520.

Karno, M. & Edgerton, R. B. Perception of mental illness in a Mexican American community. *Archives of General Psychiatry*, 1969, *20*, 233-238.

Karno, M. & Morales, A. A community mental health service for Mexican Americans in a metropolis. *Comprehensive Psychiatry*, 1971, *12*, 116-121.

Keefe, S. E., Padilla, A. M., & Carlos, M. L. *Emotional support systems in two cultures: A comparison of Mexican Americans and Anglo Americans*. Los Angeles: Spanish Speaking Mental Health Research Center, Occasional Paper No. 7, 1978.

Kline, L. Y. Some factors in the psychiatric treatment of Spanish Americans. *American Journal of Psychiatry*, 1969, *125*, 1674-1681.

Kruger, B. The relationship of ethnicity to utilization of community mental health centers (Doctoral dissertation, The University of Texas at Austin, 1974). *Dissertation Abstracts International*, 1974, *35*, 2436-B. (University Microfilm No. 74-24887).

Levine, D. Intervention in the cycle of health problems in the inner city: The role and processes of the family health workers as a paraprofessional. *American Journal of Orthopsychiatry*, 1970, *40*, 298-299.

LeVine, E. S. & Padilla, A. M. *Crossing cultures in therapy: Pluralistic counseling for the Hispanic*. Monterey, Ca.: Brooks/Cole Publishing Co., 1980.

Lopez, S. Clinical stereotypes of the Mexican American. In J. L. Martinez (Ed.), *Chicano psychology*. New York: Academic Press, 1977.

Lorion, R. P. Socioeconomic status and traditional treatment approaches reconsidered. *Psychological Bulletin*, 1973, *69*, 263-270.

Lorion, R. P. Patient and therapist variables in the treatment of low-income patients, *Psychological Bulletin*, 1974, *81*, 344-354.

Mack, C. N., James, L. E., Ramirez, J., & Bailey, J. The attitudes of Mexican American "non-help seekers" regarding help for personal problems: A pilot study. Paper presented at the Southwestern Psychological Association, El Paso, Texas, May 4, 1974.

Maldonado-Sierra, E. D., & Trent, R. D. The sibling relationship in group psychotherapy with Puerto Rican schizophrenics. *American Journal of Psychiatry*, 1960, *117*, 239-244.

Martinez, C. & Martin, H. W. Folk diseases among urban Mexican Americans. *Journal of the American Medical Association*, 1966, *196*, 161-164.

Mental Health Research Project. Field Notes 1979-1980. San Antonio, Tx.: Intercultural Development Research Association, 1980.

Miranda, M. R., Andujo, E., Caballero, I. L., Guerrero, C. C. & Ramos, R. A. Mexican American dropouts in psychotherapy as related to level of acculturation. In M. R. Miranda (Ed.), *Psychotherapy with the Spanish-speaking: Issues in research and service delivery*. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #3, 1976.

Miranda, M. R. & Castro, F. G. Culture distance and success in psychotherapy with Spanish-speaking clients. In J. L. Martinez (Ed.), *Chicano psychology*. New York: Academic Press, 1977.

Musto, D. F. Whatever happened to "Community Mental Health?" *The Public Interest*, 1975, *39*, 53-79.

Normand, W. C., Iglesias, J., & Payn, S. Brief group therapy to facilitate utilization of mental health services by Spanish-speaking patients. *American Journal of Orthopsychiatry*, 1974, *44*, 37-42.

Olmedo, E. L. Psychological testing and the Chicano: A reassessment. In J. L. Martinez (Ed.), *Chicano psychology*. New York: Academic Press, 1977.

Owan, T. C. Neighborhood based mental health: An approach to overcome inequities in mental health services delivery to racial and ethnic minorities. In D. Biegel & A. Naparstek (Eds.), *Community support systems and mental health: Building linkages*. New York: Springer Publishing Co., 1980.

Padilla, A. M., Carlos, M. L., & Keefe, S. E. Mental health service utilization by Mexican Americans. In M. Miranda (Ed.), *Psychotherapy for the Spanish speaking: Issues in research and service delivery*. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #3, 1976.

Padilla, A. M. & Ruiz, R. A. *Latino mental health: A review of the literature.* (DHEW Publication No. (HSM) 73-9143). Washington, D.C.: U.S. Government Printing Office, 1973.

Padilla, A. M. & Ruiz, R. A. Personality assessment and test interpretation of Mexican Americans: A critique. In R. Alvarez (Ed.), *Delivery of services for Latino community mental health*. *Los Angeles: Spanish Speaking Mental Health Research Center*, Monograph #2, 1975.

Padilla, A. M., Ruiz, R. A., & Alvarez, R. Delivery of community mental health services to the Spanish speaking/surnamed population. In R. Alvarez (Ed.), *Delivery of services for Latino community mental health*. *Los Angeles: Spanish Speaking Mental Health Research* Center, Monograph #2, 1975.

Phillipus, M. J. Successful and unsuccessful approaches to mental health services for an urban Hispano-American population. *Journal of Public Health*, 1971, *61*, 820-830.

Ramirez, D. G. *Analysis of the patterns of use of community mental health services by Mexican Americans in Texas*. San Antonio, Tx.: Intercultural Development Research Association, in press.

Ruiz, R. A. Relative frequency of Americans with Spanish surnames in associations of psychology, psychiatry, and sociology. *American Psychologist*, 1971, *26*, 1022-1024.

Ruiz, R. A. The delivery of mental health and social change services for Chicanos: Analysis and recommendations. In J. L. Martinez (Ed.), *Chicano psychology*. New York: Academic Press, 1977.

Ruiz, R. A., Casas, J. M. & Padilla, A. M. *Culturally relevant behavioristic counseling*. Los Angeles: *Spanish Speaking Mental Health Research Center*, Occasional Paper No. 5, 1977.

Sharfstein, S. S. Memorandum to all community mental health centers: Guidelines to CMHC services to minorities. Washington, D.C.: National Institute of Mental Health, 1978.

Souflee, F. (Ed.), *Chicano training center curriculum schema*. Houston: Chicano Training Center, Inc., 1974.

Souflee, F. & Valdez, G. *Proceedings of the Texas/New Mexico Symposium on the Delivery of Mental Health Services to Mexican Americans*. Houston: Chicano Training Center, 1978.

Szapocznik, J., Lasaga, J., Perry, P., & Solomon, J. R. Outreach in the delivery of mental health services to Hispanic elders. Hispanic Journal of Behavioral Sciences, 1979, 1, 21-40.

Torrey, E. F. The case for the indigenous therapist. Archives of General Psychiatry, 1969, 20, 365-373.

Torrey, E. F. The irrelevancy of traditional mental health services for urban Mexican Americans. Paper presented at the American Orthopsychiatry Association, San Francisco. Ca.: March, 1970.

Torrey, E.F. The mind game: Witchdoctors and psychiatrists. New York: Bantam Books, 1973.

Trevino, F. M. Community mental health center staffing patterns and their impact on Hispanic use of services. Paper presented at the Hispanic Health Services Research Conference, Albuquerque, New Mexico, 1979.

Trevino, F. M., Bruhn, J. G., & Bunce, H. Utilization of community mental health services in a Texas-Mexico border city. Social Science and Medicine, 1979, 13A, 331-334.

U.S. Bureau of the Census. Characteristics of the population, 1970, Part 45, Texas. Washington, D.C.: U.S. Government Printing Office, 1973.

Wright, B. J., & Isenstein, V. R. Psychological tests and minorities (DHEW No. ADM 78-482). Washington, D.C.: U.S. Government Printing Office, 1977.

Yamamoto, J., James, Q. C., Bloombaum, M., & Hatter, J. Racial factors in patient selection. American Journal of Psychiatry, 1967, 124, 630-636.

Yamamoto, J., James, Q. C., & Palley, N. Cultural problems in psychiatric therapy. Archives of General Psychiatry, 1968, 19, 45-49.

IDRA MENTAL HEALTH RESEARCH PROJECT

NATIONAL ADVISORY COMMITTEE

Carlos H. Arce, Ph.D.
Project Director
National Chicano Research Network
5080 Institute for Social Research
University of Michigan
Ann Arbor, MI 48106

Carmen Carrillo, Ph.D.
Director
City and County of San Francisco Community
Mental Health Services
Mission Mental Health Center
2940 16th St., Room 319
San Francisco, CA 94103

Floyd Martinez, Ph.D.
Executive Director
Boulder Community Mental Health Center
1333 Iris Ave.
Boulder, CO 80302

Amado M. Padilla, Ph.D.
Director
Spanish Speaking Mental Health Research Center
UCLA
Los Angeles, CA 90024

Marta Sotomayor, Ph.D.
Special Assistant to the Administrator
for Drug Abuse, Mental Health and Alcohol
5600 Fisher Lane
Rockville, MD 20857

Ernesto Suazo
Executive Director
New Mexico Council of Community Mental Health
Service
620 Camino de Salud, N.E.
Albuquerque, NM 87131

IDRA - MENTAL HEALTH RESEARCH PROJECT
STATE OF TEXAS ADVISORY COMMITTEE

Mr. Antonio Arrey
Chief, Program Evaluation
North Central Texas MHMR Services
202 W. Louisiana St., Suite 201
P.O. Box 387
McKinney, TX 75069

Mrs. Shirley Camfield
4014 Mattison
Ft. Worth, TX 76107

Israel Cuellar, Ph.D.
Director Houston Hall
San Antonio State Hospital
P.O. Box 23310
Highland Hills Station
San Antonio, TX 78223

Mr. John Estrada
Coordinator - Drug Abuse Services
El Paso Center for MHMR
720 E. Yandell
El Paso, TX 79902

Mrs. Janie Farris
Bay Shore MHMR Center
2001 Cedar Bayou
Baytown, TX 77520

Mrs. Adela G. Freymann
Division Director
Medical Assistance Program
City of Austin Health Dept.
1313 Sabine
Austin, TX 78701

Fernando Galan, Ph.D.
Assistant Dean
Graduate School of Social Work
University of Houston
4800 Calhoun
Houston, TX 77004

Pablo Holguin
Program Director for Mental Health
El Paso Center for Human Development
6700 Delta
El Paso TX 79905

Mr. Othon Medina
Registered Professional Engineer
1805 Tommy Aaron
El Paso, TX 79936

Mr. Alfonso Mirabal
U.S. Dept. of Commerce
Bureau of the Census
1100 Commerce
Dallas, TX 75202

Mr. John Moore, II
Texas Dept. of Human Resources
P.O. Box 2960 - 521 - A
Austin, TX 78769

Ms. Dolores Briones Ybarra
Legislative Aid
State Representative
Paul Moreno's Office
2314 Montana
El Paso, TX 79903

To obtain a list of IDRA publications, write:

Intercultural Development Research Association
5835 Callaghan, Suite 350
San Antonio, Texas 78228
(512) 684-8180